

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12169

12164

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>913 Ridgewood St.</u>		d. STREET ADDRESS <u>913 Ridgewood St.</u>	
3. NAME OF DECEASED (Type or print) <u>PANTELIO</u> First <u>ACHILLIOS</u> Middle Last		4. DATE OF DEATH Month <u>9</u> Day <u>30</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 14, 1904</u> 62 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Cyprus</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WWII</u>		16. SOCIAL SECURITY NO. <u>220-03-1364</u>	
17. INFORMANT <u>Nick Pantelides</u> Address <u>#2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Murder - perforated bowels</u> DUE TO (b) <u>5787</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> DUE TO (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Dick's melli; cancer of liver (hepatic)</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>66</u> , to <u>Sept 28</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Sept 28</u> , 19 <u>66</u> , and that death occurred at <u>7:30</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>10/1/66</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10-3-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Demetrius</u>	23d. LOCATION (City or Town) (County) (State) <u>Annapolis Md.</u>
24. FUNERAL DIRECTOR <u>John M. Taylor & Sons</u> ADDRESS <u>Annapolis, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 6 1966</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

40181

03185

CERTIFICATE OF DEATH

12165

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 1 month	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis 02-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		d. STREET ADDRESS 25 Clay Street	
3. NAME OF DECEASED (Type or print) #33154 Roland First Middle Last		4. DATE OF DEATH Month 9 Day 29 Year 19 66	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/14/1919
9. AGE (In years, log, birth day) yrs. 47		IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Odd Jobs		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME George Adams		14. MOTHER'S MAIDEN NAME Nannie Jane	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. 219-46-1603	
17. INFORMANT Hospital Records		Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 1621 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Severe Pulmonary DUE TO (c) Bronchogenic Carcinoma with Generalized Metastasis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/30/ , 19 66 , to 9/29/ , 19 66 , that (I) (we) lost the deceased alive on 9/29/ 19 66 , and that death occurred at 4:48 M, from causes on and on the date stated above.			
22a. SIGNATURE <i>L. Benedict</i>		22b. DATE SIGNED 9/30/66	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22d. ADDRESS Crownsville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-4-1966	23c. NAME OF CEMETERY OR CREMATORY Brewer Hill	23d. LOCATION (City or Town) (County) (State) Annapolis Md.
24. FUNERAL DIRECTOR William Reese		25a. REC'D BY REGISTRAR OCT 3 1966	
25b. REGISTRAR'S SIGNATURE <i>James Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

531 St. Mary

93152

FOR STATE
HEALTH DEPT.

12171

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12166

1. PLACE OF DEATH o. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	c. LENGTH OF STAY IN 1b Hrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perfy Hall	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		d. STREET ADDRESS 4124 Loch Lomond Drive	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First John Middle A. Last AGRO		4. DATE OF DEATH Month September Day 6 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3- 1929
9. AGE (In years last birthday) 37 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rigger		10b. KIND OF BUSINESS OR INDUSTRY Baltimore Rigging	11. BIRTHPLACE (State or foreign country) Baltimore Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Louis Agro	
14. MOTHER'S MAIDEN NAME Grace M.		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes Korea	
16. SOCIAL SECURITY NO. 219-22-2535		17. INFORMANT Mrs Ruth Agro Address 4124 Loch Lomond Drive	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple severe injuries 9023 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Working on roof and it gave way and fell 125 ft.	
20c. TIME OF INJURY Hour 2:00 Month 9-6 Day 1966 p.m.	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Factory	20f. (City or town) (County) (State) Glen Burnie A.A. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED September 7, 1966	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-10-1966	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore Co. Md.
24. FUNERAL DIRECTOR Lassahn Funeral Home 2401 Belair Road		25a. REC'D BY REGISTRAR SEP 13 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1810

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12172
CERTIFICATE OF DEATH
12167

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Crownsville</i> c. LENGTH OF STAY IN 1b <i>14 years</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Crownsville State Hospital</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>30-4</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> d. STREET ADDRESS <i>-</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Estelle</i> Middle <i>L</i> Last <i>Barton</i>		4. DATE OF DEATH Month <i>Sept</i> Day <i>25th</i> Year <i>1966</i>	
5. SEX <i>Fe</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/9/93</i>
9. AGE (In years last birthday) <i>73</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Hospital Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4201 Congestive heart Failure</i> DUE TO (b) <i>Myocardial Infarction.</i> DUE TO (c) <i>Arteriosclerosis.</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <i>he</i> (this hospital) attended the deceased from <i>22nd Sept, 1966</i> to <i>25th Sept, 1966</i> , that (I) (we) last saw the deceased alive on <i>25th Sept, 1966</i> , and that death occurred at <i>10:45 M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Alvin Thompson</i>		22b. DATE SIGNED <i>9/25/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Alvin Thompson</i>		22d. ADDRESS <i>Crownsville State Hosp.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>9.30-66</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>U. of Md. Med. School</i>		23d. LOCATION (City, town or county) (State) <i>Baltimore Md.</i>	
24. FUNERAL DIRECTOR <i>W. R. H. #</i>		25a. REC'D BY REGISTRAR <i>10th WASH ST</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <i>OCT 5 1966</i>	

15101

15101



CERTIFICATE OF DEATH

12178

12168

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>8 months</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNAPOLIS NURSING HOME</u>		d. STREET ADDRESS <u>WESTON</u>	
3. NAME OF DECEASED (Type or print) <u>BATES, ELIZABETH</u> First Middle Last		4. DATE OF DEATH <u>SEPT 23</u> 19 <u>66</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 31, 1889</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>JOHNSTOWN, PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN GOLLAR</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Byers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS. E.R. MEYER, DAU,</u> Address <u>SAME AD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SHOCK</u> DUE TO (b) <u>ENDOTOXINS, GRAM-NEGATIVE ORGANISMS</u> DUE TO (c) <u>SEPTICEMIA</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 HOURS</u> <u>4 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>OBLITERATIVE CHOLANGITIS, MULTIPLE DECUBITUS ULCERS</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9 JAN, 1966</u> to <u>23 SEP, 1966</u> that (I) (we) last saw the deceased alive on <u>21 SEP 1966</u> , and that death occurred at <u>5:00 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Charles W. Kinzer</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>23 SEP 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>CHARLES W. KINZER</u>		22d. ADDRESS <u>SOUTH RIVER MED CENT. EDGEWATER, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal-Burial</u>	23b. DATE THEREOF <u>Sept. 26, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Grandview Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Johnstown Cambria Pa.</u>
24. FUNERAL DIRECTOR <u>Beverley E. Hopping</u> <u>Hopping Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Beverley E. Hopping</u> <u>Annapolis, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>SEP 27 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12174

12169

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b Elvaton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Millersville P. O.	
3. NAME OF DECEASED (Type or print) First Middle Last Marion Lenore BLOOM		4. DATE OF DEATH Month Day Year September 24 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 26, 1926
9. AGE (In years last birthday) 40 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Severn, Md.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Allen Stevenson		14. MOTHER'S MAIDEN NAME Lenora Durner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-20-2621	
17. INFORMANT John P. Bloom, same as 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic Carcinoma of Cervix DUE TO (b) 171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 22, 1966 , to Sept 24, 1966 , that (I) (we) last saw the deceased alive on Sept 24, 1966 , and that death occurred at 6:40 P.M. M, from causes and on the date stated above.			
22a. SIGNATURE Ray M. Smith		22b. DATE SIGNED Sept 25, 1966	
22c. PHYSICIAN'S NAME (Type) RAY M. SMITH		22d. ADDRESS Sumner Park, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 28 Sept. 66	
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Md.	
24. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.		25a. REC'D BY REGISTRAR DATE SEP 29 1966	
25b. REGISTRAR'S SIGNATURE f Charles Judge			

13181

13176

Name		Address		City		State		Zip	
John F. Jones		123 Main St		New York		NY		10001	
Age		Sex		Race		Religion		Marital Status	
35		Male		White		Catholic		Married	
Education		Occupation		Income		Assets		Liabilities	
High School		Teacher		\$15,000		\$50,000		\$20,000	
Social Security No.		Veterans No.		Militia No.		Firearm No.		Motor Vehicle No.	
123-456789		987654321		543210987		210987654		876543210	
Signature		Date		Witness		Notary		Remarks	
[Signature]		10/1/50		[Signature]		[Signature]		[Text]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12175

Reg 12175

1. PLACE OF DEATH a. COUNTY <u>ANNAPOLIS</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ANN APENNELL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>615 Second Street</u>				d. STREET ADDRESS <u>615 Second Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Reba</u> Middle <u>Pinkney</u> Last <u>Booth</u>				4. DATE OF DEATH Month <u>9</u> Day <u>27</u> Year <u>1966</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 6, 1902</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LONDON PINKNEY</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH PARKER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Mary Ellen Henderson</u> Address <u>ANNAPOLIS, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Cervix</u> DUE TO <u>171X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Life</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1964</u> , 19 <u> </u> , to <u>1966</u> , 19 <u> </u> , that I last saw the deceased alive on <u>9/27/66</u> , 19 <u> </u> , and that death occurred at <u>10 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. Linhardt</u>				M.D. <u>Annopolis Md</u>			
PHYSICIAN'S NAME (Type) <u>E. Linhardt</u>				ADDRESS (Street, city or town, state) <u>Annopolis - Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>10/1/66</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ANNAPOLIS, Neck</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John B. Johnson Jr</u>				ADDRESS <u>Annopolis, Md</u>			
24a. REC'D BY REGISTRAR DATE <u>OCT 3 1966</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

CERTIFICATE OF DEATH

1921

NAME OF DECEASED <i>Robert Lee Smith</i>		AGE <i>35</i>		SEX <i>Male</i>	
DATE OF DEATH <i>April 15, 1921</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Birmingham</i>	
CAUSE OF DEATH <i>Heart failure</i>		DISEASE OR INJURY <i>Myocarditis</i>		DIAGNOSIS <i>Myocarditis</i>	
PLACE OF BIRTH <i>Alabama</i>		DATE OF BIRTH <i>March 10, 1886</i>		AGE AT DEATH <i>35</i>	
OCCUPATION <i>Teacher</i>		EDUCATION <i>High School</i>		RELIGION <i>Methodist</i>	
MARRIED <i>Yes</i>		SINGLE <i>No</i>		DIVORCED <i>No</i>	
WIDOWED <i>No</i>		SEPARATED <i>No</i>		OTHER <i>No</i>	
SIGNATURE OF DECEASED <i>Robert Lee Smith</i>		SIGNATURE OF WITNESS <i>John Doe</i>		SIGNATURE OF PHYSICIAN <i>Dr. J. H. Brown</i>	
SIGNATURE OF CLERK <i>John Doe</i>		SIGNATURE OF REGISTRAR <i>John Doe</i>		SIGNATURE OF JUDGE <i>John Doe</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>North Arundel Hospital</u>						d. STREET ADDRESS <u>Ross Cove and Holly Pt. Dr. (Lakeside)</u>							
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Leonard</u> Last <u>Bousha</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>4</u> Year <u>1966</u>			5. SEX <u>Male</u>			6. COLOR OR RACE <u>White</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>March 7, 1903</u>			9. AGE (In years last birthday) <u>63</u> yrs.			IF UNDER 1 YEAR: Months <u>6</u> Days <u>3</u> Hours <u>15</u> Min. <u>00</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Edgar Boushell</u>						14. MOTHER'S MAIDEN NAME <u>Irene (unknown)</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>219-32-0749</u>			17. INFORMANT <u>Mrs. Rose A. Boushell (Wife)</u>			Address <u>Same As #2</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Generalized Carcinoma of Bowel</u> DUE TO (b) <u>1539</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>1 1/2 months</u>												INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>9/4</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Sept 4</u> , 19 <u>66</u> , and that death occurred at <u>7:45 PM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>Paul J. Chang</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>September 4, 1966</u>				
22c. PHYSICIAN'S NAME (Type) <u>Paul J. Chang, M.D.</u>						22d. ADDRESS <u>801 Crain Hwy SE, Glen Burnie</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Sept. 7, 1966</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Park</u>			23d. LOCATION (City, town or county) (State) <u>Glen Burnie, Md.</u>				
24. FUNERAL DIRECTOR <u>R. V. Singleton</u>			ADDRESS <u>Glen Burnie, Md.</u>			25a. REC'D BY REGISTRAR <u>SEP 7 1966</u>			25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>				

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12177

12172

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE OREGON b. COUNTY MULTNOMAH			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT GEO G MEADE, MD			c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PORTLAND		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL, FGGMMD				d. STREET ADDRESS 16820 S.E. ADLER ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THOMAS Middle JAMES Last BRANDLOF				4. DATE OF DEATH Month SEPT Day 10 Year 1966			
5. SEX MALE		6. COLOR OR RACE CAU		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4 FEB 49	
9. AGE (In years last birthday) yrs. 17		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SOLDIER		11. BIRTHPLACE (County & State, or foreign country) COOK, ILLINOIS		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES N. BRANDLOF				14. MOTHER'S MAIDEN NAME SHIRLEY J. WILLIAMS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES		16. SOCIAL SECURITY NO. 18 Mar 66-10 Sept 66/328-38-9072		17. INFORMANT Address 16820 S.E. Adler JAMES N. BRANDLOF Portland, Ore.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) POSSIBLE HEAD INJURY AND INTERNAL INJURY DUE TO AUTO ACCIDENT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) AUTO ACCIDENT			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) AUTO ACCIDENT				
20c. TIME OF INJURY Month, Day, Year Hour 2230 p.m. Sept 10 19 66			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) FGGMMD		20f. (City or town) (County) (State) FT GEO G MEADE, MD
21. I certify that (1) (this hospital) attended the deceased from the time of death until 10 SEPT 19 66, and that death occurred at 2230 PM, from causes and on the date stated above.							
22a. SIGNATURE Lynn W. Holder				22b. DATE SIGNED 10 SEPT 66		22c. PHYSICIAN'S NAME (Type) LYNN W. HOLDER, CAPT, MC	
22d. ADDRESS KIMBROUGH ARMY HOSPITAL, FGGMMD				22e. REC'D BY REGISTRAR DATE SEP 19 1966			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Sept. 15, 1966		23c. NAME OF CEMETERY OR CREMATORY WILLAMETTE Nat. cemetery		23d. LOCATION (City or Town) (County) (State) Portland 66, Ore.	
24. FUNERAL DIRECTOR Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland				25a. REC'D BY REGISTRAR DATE SEP 19 1966			
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				25c. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

55151

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

1 (M)

12178

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12173

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ---				c. LENGTH OF STAY IN 1b <u>NA</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>DOA USNH Annapolis, Md.</u>				e. STREET ADDRESS <u>RFD #2 Box 176</u>			
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>E.</u> Last <u>Brennan</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>13</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-17-03</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u>62</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---				10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (County & State, or foreign country) <u>Kings County, Brooklyn, N.Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Adam Rutherford</u>				14. MOTHER'S MAIDEN NAME <u>Maria Maxwell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ---				16. SOCIAL SECURITY NO. <u>219 30 4696</u>		17. INFORMANT <u>(H) John B. Brennan</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Injuries, Extreme</u> <u>8254</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Automobile accident</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State) <u>Rt. 460 West River, Annapolis</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>10 AM</u> to <u>13 SEPT 66</u> , 19--, that (I) (we) saw the deceased alive on <u>DOA</u> 19--, and that death occurred at <u>M</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>William Ross Kennedy MD</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>13 Sept. 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM ROSS KENNEDY, MD.</u>				22d. ADDRESS <u>USNH, ANNAPOLIS, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9-14-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		23d. LOCATION (City, town or county) (State) <u>Glen Burnie, Md</u>	
24. FUNERAL DIRECTOR <u>Thomas A. Houdesty 12 Ridgely Ave, Annapolis, Md</u>				25a. REC'D BY REGISTRAR <u>SEP 21 1966</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12179

12174

1. PLACE OF DEATH a. COUNTY <i>A. A.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>A. A.</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Hanover</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>A. A. General</i>				d. STREET ADDRESS <i>Box 500 Horseys</i>			
3. NAME OF DECEASED (Type or print) <i>Richard Brown</i>				4. DATE OF DEATH <i>9 6 1966</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Col.</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9-15-1912</i>	
9. AGE (In years last birthday) <i>53</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Suburban</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MD.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Herbert Brown</i>				14. MOTHER'S MAIDEN NAME <i>Ida Jones</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>				16. SOCIAL SECURITY NO. <i>A. A. 2</i>		17. INFORMANT <i>Pauline Hall</i> Address <i>Order</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4344 Cause</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <i>short</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>[Signature]</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>E. L. [Signature]</i>				M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <i>9/6/66</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE THEREOF <i>9-10-66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Tabor</i>		23d. LOCATION (City, town or county) (State) <i>Chestersfield MD.</i>	
24. FUNERAL DIRECTOR <i>William Reese</i>				25a. REC'D BY REGISTRAR <i>[Signature]</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
				DATE <i>SEP 9 1966</i>			

15116

15116

CERTIFICATE OF DEATH

12180

12175

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 7mo. 24 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital				d. STREET ADDRESS Unknown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) 3-#31197 Michael Joseph Brukiewa				4. DATE OF DEATH Month 9 Day 22 Year 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 17, 1909		9. AGE (In years last birthday) yrs. 57	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Brukiewa				14. MOTHER'S MAIDEN NAME Ida Cieslak			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW II		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 143X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Carcinoma of Floor of the mouth DUE TO (c) -----							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Alcoholism; Inanition							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour a.m. --- p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that the (this hospital) attended the deceased from 1/28 , 19 66 , to 6/22 , 1966, that (I) we saw the deceased alive on 6/22 , 19 66 , and that death occurred at 3:30 A. M, from causes and on the date stated above.							
22a. SIGNATURE <i>L. Benedict</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/22/66	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.				22d. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/24/66		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR John J. Duda Inc. 2829 Hudson St. Balto. Md.				25a. REC'D BY REGISTRAR SEP 27 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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13180

13135

CERTIFICATE OF DEATH

Name of deceased		John A. Smith	
Age		35 years	
Sex		Male	
Race		Caucasian	
Date of death		April 17, 1952	
Place of death		Home, 123 Main St., Springfield, Ill.	
Cause of death		Heart disease	
Disease or injury		Coronary artery disease	
Occupation		Engineer	
Marital status		Married	
Spouse's name		Mary A. Smith	
Signature of physician		[Signature]	
Signature of registrar		[Signature]	
Date of registration		April 18, 1952	
Place of registration		Springfield, Ill.	
Registrar's name		John Doe	
Registrar's title		Registrar	
Registrar's address		456 Elm St., Springfield, Ill.	
Registrar's phone		123-4567	
Registrar's fax		123-4567	
Registrar's email		john.doe@springfield.gov	
Registrar's website		www.springfield.gov	
Registrar's social media		@springfieldgov	
Registrar's contact info		123-4567	
Registrar's notes		[Notes]	

FOR STATE HEALTH DEPT.

12181

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12176

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN lb Annopolis d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS RFD #1, Box 213 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DANIEL Middle CLEMM Last BURTIS		4. DATE OF DEATH Month September Day 29 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-28-1928
9. AGE (In years last birthday) 38 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) C.P. TELEPHONE Co	
10b. KIND OF BUSINESS OR INDUSTRY SPICER		11. BIRTHPLACE (State or foreign country) ANNAPOLIS MD	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WILLIAM H. BURTIS	
14. MOTHER'S MAIDEN NAME LILLY LEATHERBURY		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII	
16. SOCIAL SECURITY NO. AMELIA Galloway Burtis #2		17. INFORMANT Address AMELIA Galloway Burtis #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fractures of long bones of right lower leg (c) and infected laceration of left lower leg.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver in truck-auto collision	
20c. TIME OF INJURY Month, Day, Year Hour 9 p.m. 17 19 66	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street	20f. (City or town) (County) (State) Davidsonville AA Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty EXAMINER'S NAME (Type) Charles S. Petty, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED 9/30/66			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10-1-1966	23c. NAME OF CEMETERY OR CREMATORY ST. ANNE'S CEMETERY	23d. LOCATION (City or Town) (County) (State) ANNAPOLIS MD
24. FUNERAL DIRECTOR JOHN M. TAYLOR SONS		25a. REC'D BY REGISTRAR ANNAPOLIS MD 25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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3-28-1938

C. P. Thompson Co

William H. Burris

Yes

U.S.A.

Annapolis Md

Lux Leatherbury

Amelia Galloway Burris

BURIAL 10-1-1938 ST ANNE'S CEMETERY ANNAPOLIS MD

John M. Taylor & Sons Annapolis Md

TO HOSPITAL. The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.

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VR A15
ISM 7

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12182

12177

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Erans Caswood Caywood</u>		4. DATE OF DEATH Month Day Year <u>9 24 19 66</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/22/1908</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ODELL CAYWOOD</u>		14. MOTHER'S MAIDEN NAME <u>Virginia BASS FERRI</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> 491X Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>it</u> (this hospital) attended the deceased from <u>9/24/66</u> 19 <u>66</u> to <u>9/25/66</u> 19 <u>66</u> , that <u>it</u> (we) last saw the deceased alive on <u>9/24/66</u> 19 <u>66</u> , and that death occurred at <u>6:30 P</u> M, from the causes and on the date stated above.		22b. DATE SIGNED <u>9/25/66</u>	
22a. SIGNATURE <u>[Signature]</u>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>L. BENEDICT M.D.</u>		22d. ADDRESS <u>Brownsville State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/28/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Christ Church</u>		23d. LOCATION (City, town or county) (State) <u>Chgtun Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>McClair Matten by Leonardton, Md</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 27 1966</u>	
ADDRESS <u>McClair Matten by Leonardton, Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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12183

CERTIFICATE OF DEATH

13564

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 5 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Churchton	
3. NAME OF DECEASED (Type or print) First William Middle (none) Last COLLINSON		4. DATE OF DEATH Month September Day 20 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Aug. 31, 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building	9. AGE (In years lost birthday) 77 yrs.
11. BIRTHPLACE (County & State, or foreign country) Sudley, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Collinson		14. MOTHER'S MAIDEN NAME ELLA WARD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 213 14 0607	
17. INFORMANT George W. Collinson		Address Deale Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac standstill (arrest) DUE TO (b) Acute (anterior) myocardial infarction DUE TO (c) Arteriosclerosis, general and coronary CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4201			INTERVAL BETWEEN ONSET AND DEATH 10 minutes 5 days many years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Diabetes mellitus, pulmonary emphysema, congestive heart failure			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (Richard) attended the deceased from 15 Sep , 19 66 , to Sept. 20 19 66 , that (I) (was) last saw the deceased alive on Sept. 20 , 19 66 , and that death occurred at 11:15 AM , from causes and on the date stated above.			
22a. SIGNATURE Charles W. Kinzer		22b. DATE SIGNED Sept 20, 1966	
22c. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M. D.		22d. ADDRESS South River Medical Center Edgewater, Maryland 21037	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10-23-66	23c. NAME OF CEMETERY OR CREMATORY Woodfield	23d. LOCATION (City or town) (County) (State) Galesville, Md
24. FUNERAL DIRECTOR TA Hardisty, Galesville, Md		25a. REC'D BY REGISTRAR DATE OCT 10 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2001

RESULTS

• *Journal of Management Education*, 2000, 24(1), 10-12.

Lucy

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(2000) 11th edn, p. 111.

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Page 10 of 13

12184

CERTIFICATE OF DEATH

12179

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEVERN</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hosp.</u>		d. STREET ADDRESS <u>Evergreen Road</u>	
3. NAME OF DECEASED (Type or print) <u>Lillian</u> First <u>Cooper</u> Middle Last		4. DATE OF DEATH <u>9/13</u> Month Day Year 19 <u>66</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-13-93</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE (In years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <u>Balto, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Howard T. Davenport</u>		14. MOTHER'S MAIDEN NAME <u>Ella Null</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, of unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. George N. Cooper (Husband)</u> Address <u>Same as #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>menia</u> <u>1538</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>intestinal obstruction</u> DUE TO (c) <u>Carcinoma of the Colon</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Gremia</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>August</u> , 19 <u>66</u> to <u>Sept 14</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9-14-66</u> 19 <u>66</u> , and that death occurred at <u>11:30 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Isaiah G. Groll</u>		22b. DATE SIGNED <u>9-14-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Franz X. Groll</u>		22d. ADDRESS <u>5 Central Ave Glen Burnie</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept-14-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u>	23d. LOCATION (City or town) (County) (State) <u>Glen Burnie, Md.</u>
24. FUNERAL DIRECTOR <u>R. Simpson</u>		25a. REC'D BY REGISTRAR <u>SEP 15 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

18131

EXHIBIT OF DEATH

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18131		EXHIBIT OF DEATH		18131	
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12185

CERTIFICATE OF DEATH

12180

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	
c. LENGTH OF STAY IN 1b /////		d. STREET ADDRESS #7833 Americana Circle	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) N. Arundel Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMIE First Middle Last		4. DATE OF DEATH Sept. 12 19 66 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 9, 1909
9. AGE (In years lost birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY Davison Chem. Co. Richmond, Va.	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jamie R. Crawford Sr.		14. MOTHER'S MAIDEN NAME Effie Cottrell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 216-18-0517	
17. INFORMANT Mrs. Nancy E. Crawford (wife) Same as #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis, acute 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral iliac arterial occlusion. Vein graft Apr. 1966		INTERVAL BETWEEN ONSET AND DEATH 30 min	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 1966	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 1965 , to Sept. 1966 , that (I) (we) last saw the deceased alive on Sept. 1966 , and that death occurred at 2:30 AM from causes and on the date stated above.			
22a. SIGNATURE Francis I. Codd M.D.		22b. DATE SIGNED 9-13-66	
22c. PHYSICIAN'S NAME (Type) Francis I. Codd M.D.		22d. ADDRESS Severna Park, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 15, 66	
23c. NAME OF CEMETERY OR CREMATORY Balto. Nat'l. Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Singleton Funeral Home, Glen Burnie, Md.		25a. REC'D BY REGISTRAR SEP 15 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

M

12186

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12181

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Davidsonville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN		First Middle Last HENRY DAVIS		4. DATE OF DEATH Month September Day 17 Year 19 66			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-4-1920		9. AGE (In years lost birthday) 46 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Paul Eugene Davis			14. MOTHER'S MAIDEN NAME Hester Green				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-127872		17. INFORMANT Esther Davis Address 10 Hicks Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Traumatic Injuries. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver in auto-auto collision.					
20c. TIME OF INJURY Hour 8:00 p.m. Month, Day, Year 9/17 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) A.A. (County) Md. (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Petty		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 9/18/66	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-22-1966		23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		23d. LOCATION (City or Town) Md. (County) Md. (State)	
24. FUNERAL DIRECTOR William Reese		ADDRESS #1000		25a. REC'D BY REGISTRAR SEP 20 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12187

12182

1. PLACE OF DEATH a. COUNTY <u>AA CV</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA CV</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>P.O. - Rumbrough</u>		d. STREET ADDRESS <u>543 Maple Ridge RD.</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Grace</u> Last <u>Deering</u>		4. DATE OF DEATH Month <u>9</u> Day <u>14</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 8 1899</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life) <u>Receptionist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Salerno, Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ferdinand Russo (Deceased)</u>		14. MOTHER'S MAIDEN NAME <u>Anna G. Russo Deceased</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>004-05-3810</u>	
17. INFORMANT <u>Mr. Lawrence Deering</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4344</u> DUE TO <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Stroke</u> (b) _____ DUE TO _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhart</u>		M.D.	
EXAMINER'S NAME (Type)		22. DATE SIGNED <u>9-14-66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Sept. 17, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Portland, Maine</u>	
24. FUNERAL DIRECTOR <u>Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 13 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. PLACE OF BIRTH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN TB <u>1 mo. 26 yrs. 27 days</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>Unknown</u>	
3. NAME OF DECEASED (Type or print) <u>3-#06871</u> First <u>Louise</u> Middle <u>Deville</u> Last <u>Deville</u>		4. DATE OF DEATH Month <u>9</u> Day <u>1</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1911</u>
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Deville</u>		14. MOTHER'S MAIDEN NAME <u>Alice</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Hospital Records</u>		Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> <u>260X</u> DUE TO <u>Due: Decubitus Ulcers</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bilateral Amputation</u> DUE TO (c) <u>Diabetes Mellitus</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <u>Schizophrenia-Paranoid, Generalized Arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour _____ min. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) -----
21. I certify that (I) (this hospital) attended the deceased from <u>7/4</u> , 19 <u>66</u> to <u>9/1</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9/1</u> , 19 <u>66</u> , and that death occurred at <u>10:30</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Lionel McHenry Mapp</u>		22b. DATE SIGNED <u>9/1/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M.D.</u>		22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>9/5/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill</u>	23d. LOCATION (City or Town) (County) (State) <u>Clinton Md</u>
24. FUNERAL DIRECTOR <u>Rollins 4339 - Hunt PL</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 6</u> 1966	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

15181

STATE OF TEXAS

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COUNTY OF _____		CITY OF _____	
NAME OF DEBTOR _____		NAME OF CREDITOR _____	
DEBTOR'S ADDRESS _____		CREDITOR'S ADDRESS _____	
DEBTOR'S OCCUPATION _____		CREDITOR'S OCCUPATION _____	
DEBTOR'S ANNUAL INCOME _____		CREDITOR'S ANNUAL INCOME _____	
DEBTOR'S ASSETS _____		CREDITOR'S ASSETS _____	
DEBTOR'S LIABILITIES _____		CREDITOR'S LIABILITIES _____	
DEBTOR'S CREDIT HISTORY _____		CREDITOR'S CREDIT HISTORY _____	
DEBTOR'S CHARACTER _____		CREDITOR'S CHARACTER _____	
DEBTOR'S MARRIAGE HISTORY _____		CREDITOR'S MARRIAGE HISTORY _____	
DEBTOR'S EDUCATION _____		CREDITOR'S EDUCATION _____	
DEBTOR'S EMPLOYMENT HISTORY _____		CREDITOR'S EMPLOYMENT HISTORY _____	
DEBTOR'S SOCIAL HISTORY _____		CREDITOR'S SOCIAL HISTORY _____	
DEBTOR'S LEGAL HISTORY _____		CREDITOR'S LEGAL HISTORY _____	
DEBTOR'S OTHER INFORMATION _____		CREDITOR'S OTHER INFORMATION _____	

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FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie (Marley Pk.)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie, (Marley Pk.)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 203 Summit Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MILORED Middle M. Last DINGLEY		4. DATE OF DEATH Month September Day 2 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 July 1899
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME (unknown) Atwood		14. MOTHER'S MAIDEN NAME (unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Catherine Weigand - Same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral aneurysm - R. branch</i> 1992 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>E. Linhardt</i> EXAMINER'S NAME (Type) E. Linhardt		22. DATE SIGNED 9/2/66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5 Sept. 66	
23c. NAME OF CEMETERY OR CREMATORY Our Lady Catholic Cemetery		23d. LOCATION (City, town or county) (State) Millersville, Md.	
24. FUNERAL DIRECTOR <i>Robert P. Williams</i> ADDRESS Singleton Funeral Home/Glen Burnie, Md.		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE SEP 6 1966 <i>J. Charles Judge</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2013

28181

CERTIFICATE OF DEATH

12180

12185

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>—</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crownsville</i>		c. LENGTH OF STAY IN 1b <i>34 years</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crownsville Baltimore 30-4</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Crownsville State Hosp.</i>		d. STREET ADDRESS <i>1812 Penrose Ave.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>#03682 Carrie Dixon</i>		4. DATE OF DEATH Month <i>Sept.</i> Day <i>22nd</i> Year <i>1966</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>My</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/11/1893</i>
9. AGE (In years lost birthday) <i>73</i> yrs.		10. IF UNDER 1 YEAR Months <i>—</i> Days <i>—</i> Hours <i>—</i> Min. <i>—</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>—</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (County & State, or foreign country) <i>U.S.A.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME	
14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Hospital Records</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of Breast.</i> DUE TO <i>170X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <i>—</i> DUE TO <i>—</i> (c) <i>—</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>—</i> p.m. <i>—</i> 19 <i>—</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) (County) (State) <i>—</i>
21. I certify that (I) (this hospital) attended the deceased from <i>9/1</i> , 19 <i>32</i> , to <i>9/22</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>9/22</i> , 19 <i>66</i> , and that death occurred at <i>5:45 AM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Alvin Thompson</i>		22b. DATE SIGNED <i>9/22/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Alvin Thompson</i>		22d. ADDRESS <i>Crownsville State Hosp.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE THEREOF <i>9.30.66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>V. J. Med. School</i>	23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Md.</i>
24. FUNERAL DIRECTOR <i>W. Reese H.</i>		25a. REC'D BY REGISTRAR <i>108 W. W. ST</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <i>OCT 5 1966</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18189

DEPARTMENT OF HEALTH

18189

RECEIVED
JAN 10 1944
U.S. DEPARTMENT OF HEALTH
BUREAU OF PUBLIC HEALTH
DIVISION OF VETERINARY MEDICINE
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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20 M 1/66

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #2 infor taken from birth cert.

12191

CERTIFICATE OF DEATH

12186

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE NA/ Md. b. COUNTY NA/ A.A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT GEORGE G. MEADE			c. LENGTH OF STAY IN 1b NA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NA// Glen Burnie		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL				d. STREET ADDRESS NA 1019 Genine Dr.		e. IS RESIDENCE ON A FARM? YES NA NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last (NOT NAMED) DOMINICK				4. DATE OF DEATH Month Day Year September 2, 1966			
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> NA DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 2, 1966		9. AGE (In years last birthday) yrs. 1	IF UNDER 1 YEAR Months Days Hours Min. 55	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10b. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (County & State, or foreign country) ANNE ARUNDEL, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN A. DOMINICK				14. MOTHER'S MAIDEN NAME GRACE SUTTLES			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NA		16. SOCIAL SECURITY NO. NA		17. INFORMANT JOHN A. DOMINICK Address 1019 Genine Drive, Glen Burnie, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia neonatorum 7620 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NA						INTERVAL BETWEEN ONSET AND DEATH 1 hr, 55 min	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NA		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NA					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. NA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) NA		20f. (City or town) (County) (State) NA	
21. I certify that (I) (the hospital) attended the deceased from September 2 1966 , to September 2 1966 , that (I) (xxx) last saw the deceased alive on 2 September 1966 , and that death occurred at 9:00 a.m. from causes and on the date stated above.							
22a. SIGNATURE THEODORE F. TOULAN				22b. DATE SIGNED September 2, 1966		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) THEODORE F. TOULAN, M.D.				22d. ADDRESS Kimbrough Army Hosp, Ft G G Meade, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF September 6, 1966		23c. NAME OF CEMETERY OR CREMATORY Kimbrough Army Hospital		23d. LOCATION (City or Town) (County) (State) Ft G G Meade, Anne Arundel, Md.	
24. FUNERAL DIRECTOR Jonathan Roberts, CPT, MSC, Kimbrough AH, Ft G. G. Meade, Md.				25a. REC'D BY REGISTRAR DATE SEP 14 1966		25b. REGISTRAR'S SIGNATURE J Charles Judge	

12121

12121

NAME		JOHN A. DOMINICK	
GRADE		MAJOR	
COMPONENT		ARMY	
BRANCH		INFANTRY	
REGIMENT		1ST REGIMENT	
BATTALION		1ST BATTALION	
COMPANY		1ST COMPANY	
PLATOON		1ST PLATOON	
SECTION		1ST SECTION	
SERIAL		1000	
DATE		10/1/50	
PLACE		FORT MONMOUTH, NEW JERSEY	
REMARKS		1. 10/1/50 - 10/1/50	
SIGNATURE		[Signature]	
TITLE		[Title]	
OFFICE		[Office]	
ADDRESS		[Address]	
CITY		[City]	
STATE		[State]	
ZIP		[ZIP]	
COUNTRY		[Country]	
TELEPHONE		[Telephone]	
FAX		[Fax]	
E-MAIL		[E-Mail]	
WEBSITE		[Website]	
OTHER		[Other]	

CERTIFICATE OF DEATH

12192

12187

1. PLACE OF DEATH a. COUNTY A.A. MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT GEO G MEADE, MD c. LENGTH OF STAY IN lb DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL, FGGMD				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST MICHAELS, MARYLAND d. STREET ADDRESS GRACE STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY JO DYOTT			4. DATE OF DEATH FOUND DEAD 3 SEPT 66				
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 SEPT 1948	9. AGE (In years last birthday) 17 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (County & State, or foreign country) ST MICHAELS, TALBOT, MD.			
13. FATHER'S NAME ERNEST W. DYOTT			14. MOTHER'S MAIDEN NAME CATHERINE BALL				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT ERNEST W. DYOTT: GRACE ST, ST MICHAELS, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BLUNT FORCE HEAD INJURIES; ASSOCIATED MANUAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. STRANGULATION DUE TO (c) HOMICIDAL ASSAULT BY ANOTHER					INTERVAL BETWEEN ONSET AND DEATH FOUND DEAD 3 SEPT 66		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) HOMICIDAL ASSAULT BY ANOTHER					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that THIS HOSPITAL ATTENDED THE DECEASED was DOA, 19 SEP 66 , and that death occurred at 8:05 PM , from causes and on the date stated above.							
22a. SIGNATURE Henry M. Snell		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 6 SEPT 66			
22c. PHYSICIAN'S NAME (Type) HENRY M. SNELL, CPT, MC, USA		22d. ADDRESS 1ST US ARMY LABORATORY, FGGMD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 6, 1966		23c. NAME OF CEMETERY OR CREMATORY Olivet Cemetery			
23d. LOCATION (City or Town) (County) (State) St. Michaels, Talbot Co., Md.							
24. FUNERAL DIRECTOR Hampton Harrison, St. Michaels, Md.		25a. REC'D BY REGISTRAR SEP 13 1966		25b. REGISTRAR'S SIGNATURE John C. Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

50151

02751

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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12193

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12188

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE South Carolina b. COUNTY Horry	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore-rural		c. LENGTH OF STAY IN lb Conway	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel General Hospital		d. STREET ADDRESS 1506 3rd Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last John D. Edmondson		4. DATE OF DEATH Month Day Year 9 17 19 66	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 19, 1928
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painting Contractor		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) yrs. 38
11. BIRTHPLACE (State or foreign country) Horry County, S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John D. Edmondson		14. MOTHER'S MAIDEN NAME Theresa Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes World War 2		16. SOCIAL SECURITY NO.	
17. INFORMANT Charles Edmondson		Address Myrtle Beach	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) pedestrian struck by car	
20c. TIME OF INJURY Month, Day, Year 11:00 p.m. 9 17 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street
20f. (City or town) Balto.-rural		(County) (State) A.A. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED 9/19/66		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF Sept. 20, 1966	
23c. NAME OF CEMETERY OR CREMATORY Union Methodist Cemetery		23d. LOCATION (City or Town) (County) (State) Myrtle Beach S.C.	
24. FUNERAL DIRECTOR William J. Tickner & Sons		25a. REC'D BY REGISTRAR SEP 20 1966	
ADDRESS N. & Pa. Aves.		25b. REGISTRAR'S SIGNATURE Charles Judge	

1518

EX 11

2032

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12194

CERTIFICATE OF DEATH

12189

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN lb 19 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 1004 Phillip Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First James Middle Freeborough Last EKSTROM, Sr.				4. DATE OF DEATH Month September Day 20 Year 19 66				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 15, 1899		
				9. AGE (In years last birthday) yrs. 66		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) chauffer (Ret.)			10b. KIND OF BUSINESS OR INDUSTRY Shipley Trans.		11. BIRTHPLACE (County & State, or foreign country) State of Washington		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Ekstrom				14. MOTHER'S MAIDEN NAME Emma Freeborough				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 212-10-6356		17. INFORMANT Mr. Carroll L. Ekstrom (Son)		Address 616 NewJerse Ave. Glen Burnie		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA DUE TO (b) VIRAL HEPATITIS DUE TO (c) TERMINAL UREMIA							INTERVAL BETWEEN ONSET AND DEATH 12 HOURS 21 DAYS 24 HOURS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (the hospital) attended the deceased from SEPT 1, 1966 , to Sept. 20, 19 66 , that (I) (we) last saw the deceased alive on Sept. 20, 19 66 , and that death occurred at _____ M, from causes and on the date stated above.								
22a. SIGNATURE Arthur Lankford Jr.				7:00 PM M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-21-66		
22c. PHYSICIAN'S NAME (Type) ARTHUR LANKFORD JR.				22d. ADDRESS 2934 MOUNTAIN RD. PASADENA, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 24, 66		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Md.		
24. FUNERAL DIRECTOR Richard V. Singleton				ADDRESS Glen Burnie, Md.		25a. REC'D BY REGISTRAR DATE SEP 26 1966		
				25b. REGISTRAR'S SIGNATURE Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
12195					12190									
1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Pasadena, Rt. 1</i>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Pasadena Rt. 1, Box 63</i>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Oakdale Rd., Pinehurst on Bay</i>					d. STREET ADDRESS <i>Oakdale Road, Pinehurst on Bay</i>			a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <i>Thomas P. Finn, Sr.</i>					4. DATE OF DEATH Month Day Year <i>Sept. 21 1966</i>									
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <i>12-7-88</i>		9. AGE (In years last birthday) <i>77</i> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Projectionist</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Motion Pictures</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>								
13. FATHER'S NAME <i>John Finn</i>					14. MOTHER'S MAIDEN NAME <i>Katherine Zerves</i>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <i>214035486A</i>					17. INFORMANT Address <i>Mrs. Marie E. Finn, 840 Evesham Ave.</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> <i>4201</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>rheumatic heart disease</i> (a), stating the underlying cause last. } DUE TO (c) <i>pneumonitis, bacterial</i>										INTERVAL BETWEEN ONSET AND DEATH <i>IMMED.</i> <i>50-60 yrs.</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>pneumonitis, bacterial</i>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)				
21. I certify that (I) (the hospital) attended the deceased from <i>8/8/64</i> , 19 <i>64</i> , to <i>9/21</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>9/19/66</i> , 19 <i>66</i> , and that death occurred at <i>8 A.M.</i> , from the causes and on the date stated above.														
22a. SIGNATURE <i>C. Earl Hill</i> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED						
22c. PHYSICIAN'S NAME (Type) <i>C. Earl Hill, M.D.</i>					22d. ADDRESS <i>395 Ft. Smallwood Rd. Pasadena, Md. 21122</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>9/24/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer</i>			23d. LOCATION (City, town or county) <i>Balto., Md.</i>			(State)				
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Leonard J. Ruck, Inc., Balto., Md. 21214</i>					25a. REC'D BY REGISTRAR DATE <i>SEP 23 1966</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>							

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12196

12191

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> c. LENGTH OF STAY IN 1b <u>6 yrs. 4 mos.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Children's Center Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Washington, D. C.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u> d. STREET ADDRESS <u>1541 - 1st Street, S. W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>Maureen</u> Middle <u>O.</u> Last <u>Fowler</u>				4. DATE OF DEATH Month <u>September</u> Day <u>26</u> Year <u>1966</u>											
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/2/59</u>		9. AGE (in years last birthday) <u>6</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Institutionalized</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Milton Otis Fowler</u>						14. MOTHER'S MAIDEN NAME <u>Austine Sylvia Brown</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>---</u>				17. INFORMANT <u>Children's Center Hospital, Laurel, Md.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial pneumonia</u> DUE TO <u>752X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Hydrocephalus - severe</u> DUE TO (c) <u>Mental retardation - severe</u>												INTERVAL BETWEEN ONSET AND DEATH <u>One day</u> <u>Birth</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>May 19, 1960</u> to <u>Sept. 26, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept. 26, 1966</u> , and that death occurred at <u>12:20pm</u> from causes and on the date stated above.															
22a. SIGNATURE <u>James E. Boyland</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>												22b. DATE SIGNED <u>September 27, 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>JAMES E. BOYLAND, M. D.</u>						22d. ADDRESS <u>Children's Center Hospital, Laurel, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Oct. 1, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Children's Center</u>				23d. LOCATION (City or Town) (County) (State) <u>Laurel, A. A. Md.</u>					
24. FUNERAL DIRECTOR <u>Charles Judge</u> ADDRESS <u>Laurel Md.</u>						25a. REC'D BY REGISTRAR DATE <u>OCT 3 1966</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12151

RECORD OF DISEASE

12151

NAME

DATE

PLACE OF BIRTH

AGE

SEX

EDUCATION

RELIGION

PROFESSION

PREVIOUS ILLNESSES

PRESENT ILLNESS

DIAGNOSIS

PROGNOSIS

TREATMENT

DATE OF DISCHARGE

NAME OF PHYSICIAN

NAME OF HOSPITAL

DATE OF ADMISSION

13188

CERTIFICATE OF DEATH

13188

[Faint, mostly illegible text on a death certificate form. The form includes sections for personal information, cause of death, and a signature line.]

[Signature]

13188

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12198

CERTIFICATE OF DEATH

12193

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Anne Arundel General Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> 02-1	
d. STREET ADDRESS <i>Sumner Ct</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Emma Esemann Gellis</i>		4. DATE OF DEATH Month Day Year <i>Sept 4 1966</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <i>9/4/01</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerical Work</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Mar. Security Agency</i>	9. AGE (In years last birthday) <i>65</i> yrs.
11. BIRTHPLACE (County & State, or foreign country) <i>Washington D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Frank Esemann</i>		14. MOTHER'S MAIDEN NAME <i>Clara Edna Lee</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Elizabeth Dickson</i>		Address <i>Annapolis Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Emboli</i> 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Rheumatic Heart Disease - mitral Stenosis</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>7 YEARS</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hypertensive Cardiovascular Disease</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>8/24</i> , 19 <i>66</i> , to <i>9/4</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>9/4</i> , 19 <i>66</i> , and that death occurred at <i>5:45 PM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Robert D. Brien</i>		22b. DATE SIGNED <i>9/4/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Robert D. Brien</i>		22d. ADDRESS <i>121 Cathedral St, Annapolis Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>9/7/66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>CONGRESSIONAL</i>	23d. LOCATION (City or Town) (County) (State) <i>WASH. D.C.</i>
24. FUNERAL DIRECTOR <i>Lee Funeral Home 3004th ST. N.E. Wash.</i>		25a. REC'D BY REGISTRAR DATE <i>SEP 8 1966</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12194

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater, Md</u>		c. LENGTH OF STAY IN lb <u>Edgewater</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>99 DOR when brought to ARGH</u>		d. STREET ADDRESS <u>Rt 1 Box 138</u>	
3. NAME OF DECEASED (Type or print) <u>Henry W. Goetz</u>		4. DATE OF DEATH Month <u>9</u> Day <u>3</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/10/84</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Costume Business New Jersey</u>	
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Goetz</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-34-8616</u>	
17. INFORMANT <u>Mr. Joseph Peroutka, 6208 Traymore Av</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>Coronary - Sudden</u> DUE TO (b) <u>(collapsed at home on floor)</u> DUE TO (c) <u>instant</u>		INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>			
19a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		19b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no injury</u>	
20a. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Edgewater</u>		20d. (City or town) (County) (State) <u>Edgewater</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles H. Wirth M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/7/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Balto., Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. 5305 Harford Rd.</u>		25a. REC'D BY REGISTRAR <u>SEP 6 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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12200

CERTIFICATE OF DEATH

12195

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			c. LENGTH OF STAY IN lb <u>9 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>N. Arundel Gen. Hosp.</u>				d. STREET ADDRESS <u>Rt. #1 Box 188 (Elvaton Rd.)</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES F. HACKMAN</u>				4. DATE OF DEATH Month Day Year <u>Sept. 27, 1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 2, 1908</u>	
9. AGE (In years lost birthday) <u>58</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Hackman</u>				14. MOTHER'S MAIDEN NAME <u>Amelia Strobel</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>one</u>		17. INFORMANT <u>Mrs. Florence Hackman (Wife) Same as #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Acute myocardial Infarction</u> DUE TO (b) <u>Anteriorly placed Heart Disease</u> DUE TO (c) <u>Intermittent Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-19, 1966</u> , to <u>9-27, 1966</u> , that (I) (we) last saw the deceased alive on <u>9-27, 1966</u> , and that death occurred at <u>2:00 P.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Hilary M. Herlihy</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9-27-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>H.T. O'HERLIHY M.D.</u>				22d. ADDRESS <u>5 Central Ave., Glen Burnie</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 30, 66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie, Maryland</u>	
24. FUNERAL DIRECTOR <u>Richard V. Singleton</u>				25a. REC'D BY REGISTRAR <u>Glen Burnie, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

6315

CGS-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12201					12196				
1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ST. MARGARETS</u> c. LENGTH OF STAY IN 1b <u>MD.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BAY MANOR Nursing Home</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>9 Southgate Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>KATRINA</u> First <u>LOOMIS</u> Middle <u>Halligan</u> Last			4. DATE OF DEATH <u>SEPT 2</u> 19 <u>66</u> Month Day Year		9. AGE (In years last birthday) <u>90</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDDED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-11-1876</u>		11. BIRTHPLACE (County & State, or foreign country) <u>ERIE, Pa.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>			
13. FATHER'S NAME <u>JOEL PORTER LOOMIS</u>					14. MOTHER'S MAIDEN NAME <u>KATE HASKINSON</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. CHARLES ADAIR #2</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>—</u>								INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>12/2</u> , 19 <u>65</u> , to <u>9/2</u> , 19 <u>66</u> , that (I) <u>was</u> last saw the deceased alive on <u>8/26</u> 19 <u>66</u> , and that death occurred at <u>5 P</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Richard I. Hochman</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/3/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Richard I. Hochman, M.D.</u>					22d. ADDRESS <u>59 Franklin St., Annapolis, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>9-6-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>U.S. NAVAL ACADEMY</u>		23d. LOCATION (City, town or county) (State) <u>ANNAPOLIS MD.</u>		
24. FUNERAL DIRECTOR <u>JOHN M. TAYLOR & SONS ANNAPOLIS MD</u> ADDRESS					25a. REC'D BY REGISTRAR <u>SEP 7 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

John M. Tabor - 2nd Avenue MD

SEP 2 1888

BURIAL 2-2-1888 U.S. Naval Academy Annapolis MD

No

Joel Porter Loomis

Home

Female white

X

Katrina Loomis

H. Jan

29th St Ave

Annapolis

MD.

A.A.

CC

U.S.

Mr Charles Harris

Kate Harkinson

Eric. Fox

3-11-1876

29th St

✓

1818

1818

12202

CERTIFICATE OF DEATH

12197

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 917 Creek Drive		d. STREET ADDRESS 917 Creek Drive	
3. NAME OF DECEASED (Type or print) First Sarah Middle Irene Last Hallock		4. DATE OF DEATH Month September Day 27 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. 68
11. BIRTHPLACE (County & State, or foreign country) SHADY SIDE, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHN A. HALLOCK		14. MOTHER'S MAIDEN NAME SARAH V. PROUT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates at service) NO		16. SOCIAL SECURITY NO. Mrs. P.J. NEIMILLER	
17. INFORMANT #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO acute dilatation of the heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocardial infarction (c) hypertension			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Colitis (Chronic)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the doctor) attended the deceased from 9/21 , 19 66 , to 9/27 , 19 66 , that (I) xxx last saw the deceased alive on 9/27 , 19 66 , and that death occurred at 1:07 M, from causes and on the date stated above.			
22a. SIGNATURE Albert L. Anderson		22b. DATE SIGNED 9/28/66	
22c. PHYSICIAN'S NAME (Type) Albert L. Anderson, M.D.		22d. ADDRESS 44 Southgate Ave., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 9-29-66	23c. NAME OF CEMETERY OR CREMATORY QUAKER Burying Ground	23d. LOCATION (City or Town) (County) (State) WEST RIVER MD.
24. FUNERAL DIRECTOR John M. Lytle for Annapolis, Md.		25a. REC'D BY REGISTRAR SEP 29 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

18103

18303

John A. Hallcock

John A. Hallcock

John A. Hallcock

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John A. Hallcock

12203

CERTIFICATE OF DEATH

12198

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie, Md.		c. LENGTH OF STAY IN lb 9 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 25, Maryland		02-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		d. STREET ADDRESS 5115 Patrick Henry Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William am First Middle J. Haney Lost		4. DATE OF DEATH September 15 Day 19 Year 66	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/25/07
9. AGE (In years last birthday) yrs. 59		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Backhoe operator		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nimrod Haney		14. MOTHER'S MAIDEN NAME Ada F McDaniel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW 11		16. SOCIAL SECURITY NO. 214-01-7791	
17. INFORMANT Mrs. Leona Braun Address 5115 Patrick Henry Drive (sister)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure 4341 DUE TO Pulmonary Embolism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Congestive Heart Failure & Pneumonia (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from September 6, 1966 to September 15, 1966 , that (I) (we) saw the deceased alive on September 15, 1966 , and that death occurred at 8:10 PM , from causes and on the date stated above.			
22a. SIGNATURE Benjamin S. Linn		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/19/66	23c. NAME OF CEMETERY OR CREMATORY Parkwood	23d. LOCATION (City or Town) (County) (State) Baltimore Maryland
24. FUNERAL DIRECTOR Leonard J Ruck Inc. 5305 Harford Rd		25a. REC'D BY REGISTRAR SEP 19 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

13114

REPORT OF LOSS

13114

Name of insured		Address of insured	
Occupation of insured		Date of loss	
Description of property lost		Estimated value of property lost	
Cause of loss		Amount of loss	
Signature of insured		Signature of agent	
Date of report		Date of payment	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12204

CERTIFICATE OF DEATH

12199

1. PLACE OF DEATH a. COUNTY <u>J.A. North</u> <u>Charles</u> <u>Harrison</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Rt #2 Box 100 Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>Finksburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Carroll Md</u>	
3. NAME OF DECEASED (Type or print) <u>Charles Ralph Harrison</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>7</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-7-10</u>
9. AGE (In years lost birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>6</u> Hours <u>10</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wax man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Tyson C. Harrison</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Steffey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-07-4221</u>	
17. INFORMANT <u>Mrs. Fearn Harrison</u>		Address <u>Finksburg, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>2 day</u> <u>year</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 day</u> <u>year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ureabatos mellitis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/5/66</u> , 19 <u>66</u> , to <u>9/17/66</u> , 19 <u>66</u> , that (I) (we) saw the deceased alive on <u>9/17/66</u> 19 <u>66</u> , and that death occurred at <u>9:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>David Abramson</u>		22b. DATE SIGNED <u>9/8/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>David Abramson</u>		22d. ADDRESS <u>702 Balto Annap Bldg</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/10/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Finksburg Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Finksburg, Md.</u>
24. FUNERAL DIRECTOR <u>J. F. Eline & Sons</u>		25a. REC'D BY REGISTRAR <u>SEP 13 1966</u>	
ADDRESS <u>Reisterstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

15189

CERTIFICATE OF DEATH

15384

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

12205

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12200

1. PLACE OF DEATH a. COUNTY <u>A. A. CO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AN CO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis.</u>			c. LENGTH OF STAY in lb <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shoreham Beach Mayo</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. - ANNE ARUNDEL - GENERAL.</u>				d. STREET ADDRESS <u>Shoreham Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James.</u> Middle <u>Dudley</u> Last <u>Harty</u>			4. DATE OF DEATH Month <u>9</u> Day <u>27</u> Year <u>19 66</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-3-09</u>		9. AGE (In years last birthday) yrs. <u>57</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mar. shipping dept.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>J.B.M.</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James Harty</u>			14. MOTHER'S MAIDEN NAME <u>Eleanor Maney</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes WW II</u>		16. SOCIAL SECURITY NO. <u>577-01-6403</u>		17. INFORMANT <u>Mrs. Wilma S. Harty</u> Address <u>Shoreham Beach Rd. Mayo, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac disease</u> 4344 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>9-27-66</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt - Annapolis, Md.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sep. 30, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u>		ADDRESS <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>SEP 30 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute in duplicate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

FOR STATE
HEALTH DEPT.

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12206

12201

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital			2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale d. STREET ADDRESS 6213 - 60th Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last ARTHUR C. HISE			4. DATE OF DEATH Month Day Year September 21 19 66		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Aug 22, 1888		9. AGE (in years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U S Government		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U S A					
13. FATHER'S NAME William Hise			14. MOTHER'S MAIDEN NAME Louise Kopp		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) yes W W I			16. SOCIAL SECURITY NO.		
17. INFORMANT Ruth Reisinger			Address Rockville, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushing Chest Injuries 8169 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Head on collision - Driver			
20c. TIME OF INJURY Hour a.m. 9:40 Month, Day, Year 9/21 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	
20f. (City or town) Anne Arundel		20g. (County)		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9/21/66 EXAMINER'S SIGNATURE <u>Rudiger Breitenecker</u> EXAMINER'S NAME (Type) Rudiger Breitenecker, M.D. Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 24, 1966		22c. NAME OF CEMETERY OR CREMATOR George Washington	
22d. LOCATION (City, town, or country) Hyattsville, Md.		22e. (State)			
23. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR SEP 26 1966	
24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE			

1955

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12207 CERTIFICATE OF DEATH 12202									
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Millersville c. LENGTH OF STAY IN 1b 02-1 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Knollwood Nursing Home					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Gambrills, d. STREET ADDRESS Rutland Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Emily Summerville Hopkins			First Middle Last		4. DATE OF DEATH Sept. 28 19 66		Month Day Year		
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 7, 1885		9. AGE (in years last birthday) 81 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) teacher		10b. KIND OF BUSINESS OR INDUSTRY Public High School		11. BIRTHPLACE (County & State, or foreign country) Anne Arundel Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Samuel Snowden Hopkins					14. MOTHER'S MAIDEN NAME Elizabeth Linthicum				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-48-4937-T		17. INFORMANT Nancy P. Hopkins - sister same as #2 above					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio-Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4221 DUE TO (b) Chronic Aortic dilatation of Heart DUE TO (c) Chronic Calities								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 8/24/66 , 19 66 , to 9/28/66 , that (I) (we) last saw the deceased alive on 9/26/66 , 19 66 , and that death occurred at 5:41 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Albert L. Anderson					22b. DATE SIGNED 9/28/66		22c. PHYSICIAN'S NAME (Type) ALBERT L. ANDERSON-M.D.		
22d. ADDRESS ANNAPOLIS, M.D.					22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 30, 1966		23c. NAME OF CEMETERY OR CREMATORY St. Stephens Cemetery		23d. LOCATION (City, town or county) (State) Millersville Md.			
24. FUNERAL DIRECTOR Beverly L. Hopping HOPPING FUNERAL HOME					25a. REC'D BY REGISTRAR OCT 3 1966				
25b. REGISTRAR'S SIGNATURE J. Charles Judge									

12308

12308

White female

Age 19

High school graduate

Single

White female

Teacher

Current address

81

March 7, 1932

Public High School

Address

117-10-1937-1 March 7, 1932 - March 7, 1932

White female, single, teacher
at present address
at present address

White female
at present address
at present address

Address

Address

Address

Address

Address

Address

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
12208		CERTIFICATE OF DEATH	
12203			
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New York b. COUNTY Hartsdale c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 69-23 d. STREET ADDRESS 88 Charlot Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Miriam Adams		4. DATE OF DEATH Month September Day 29 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28, 1879
9. AGE (In years lost birthday) 87 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOMEMAKER	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME JAMES ADAMS		14. MOTHER'S MAIDEN NAME MARY LITCHFIELD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. HOSPITAL RECORDS	
17. INFORMANT HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 331X (b) Hypertension DUE TO + (c) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 12-2			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) John M. Taylor attended the deceased from 9-17-66 to Sept. 29, 1966 , that (I) John last saw the deceased alive on Sept. 29, 1966 , and that death occurred at 8 M, from causes and on the date stated above.			
22a. SIGNATURE John M. Taylor		22b. DATE SIGNED 12:15 PM 7-30-66	
22c. PHYSICIAN'S NAME (Type) F.M. SHIPLEY		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, or REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10-2-1966	23c. NAME OF CEMETERY OR CREMATORY JUNE CEMETERY	23d. LOCATION (City or Town) (County) (State) N. SALEM WESTCHESTER CO NY
24. FUNERAL DIRECTOR JOHN M. TAYLOR SONS ANNAPOLIS MD.		25a. REC'D BY REGISTRAR DATE OCT 4 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

ISSUE

12202

New York

and family

Minneapolis

and General Hospital

22 Columbia Place

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September

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Virginia

Hennepin

Hennepin

Mark Litchfield

James Adams

Hospital Records

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John M. Taylor and Associates Ltd

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

12203

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12204

1. PLACE OF DEATH a. COUNTY <u>ANNE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus Beach</u>	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus Beach</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1002 Park Place</u>		d. STREET ADDRESS <u>1002 Park Place</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Melvin</u> Middle <u>J.</u> Last <u>Hyser</u>		4. DATE OF DEATH Month <u>9</u> Day <u>23</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>8/4/08</u>
9. AGE (In years, last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months <u>19</u> Days <u>23</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Actor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Entertainment</u>	11. BIRTHPLACE (State and foreign country) <u>Ind</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Harry M.</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Rebeck</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>	
16. SOCIAL SECURITY NO. <u>2-3-09-9820</u>		17. INFORMANT <u>Family - Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u> DUE TO (b) <u>Crown atherosclerosis</u> DUE TO (c) <u>Sudden</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22. DATE SIGNED <u>9.13.66</u>		23. NAME OF CEANTRY OR CREMATORY <u>Catholic</u>	
24. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		25. REC'D BY REGISTRAR DATE <u>SEP 26 1966</u>	
26. FUNERAL DIRECTOR <u>McCurry - 1300 E. Ford St.</u>		27. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12210					12205				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)				
a. COUNTY <i>B. & C.</i> MARYLAND					a. STATE <i>Maryland</i> b. COUNTY <i>B. & C.</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. LENGTH OF STAY IN 1b <i>4 mos.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>				d. STREET ADDRESS <i>611 Delaware Ave</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Bay Manor N/ Home</i>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last <i>MARY J. Keller</i>					Month Day Year <i>Sept. 9 1966</i>				
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10 June 1891</i>		9. AGE (In years last birthday) <i>85</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>John Scheerer</i>					14. MOTHER'S MAIDEN NAME <i>Mary Nizer</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>214-56-0087</i>		17. INFORMANT <i>Elsie P. Keller - Son</i>		Address <i>Some</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <i>Cerebral arteriosclerosis</i> DUE TO (c) <i>unknown</i>								INTERVAL BETWEEN ONSET AND DEATH <i>48 hours</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>4/21</i> , 19 <i>66</i> to <i>9/2</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>9/2</i> , 19 <i>66</i> , and that death occurred at <i>10:30</i> A.M. from the causes and on the date stated above.									
22a. SIGNATURE <i>Richard I. Hochman</i>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>9/3/66</i>		
22c. PHYSICIAN'S NAME (Type) <i>Richard I. Hochman, MD</i>					22d. ADDRESS <i>59 Franklin St. Annapolis, Md</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>9/6/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Meadowridge, Manassas</i>		23d. LOCATION (City, town or county) (State) <i>Howard Co.</i>			
24. FUNERAL DIRECTOR <i>Robert K. Singleton</i>					ADDRESS <i>Funeral Home/Bay Manor, Md</i>		25a. REC'D BY REGISTRAR <i>SEP 7 1966</i>		25b. REGISTRAR'S SIGNATURE <i>John Charles Judge</i>

12805

12810

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Government of India
at the Government Press, Calcutta
1966

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12211

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12206

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HACO</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEVERN (Blon Burnie)</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SOMMERSCT. ROAD - SEVERN. 40</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.H. - NORTH. MUNDOL. Hosp.</u>			d. STREET ADDRESS <u>Box - 193-A - Rt 3 - 21144</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>IT</u> Last <u>KNOTT</u>			4. DATE OF DEATH Month <u>9</u> Day <u>15</u> Year <u>1966</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-27-00</u>		9. AGE (In years last birthday) <u>65</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>	
13. FATHER'S NAME <u>E.A. LOCKARD</u>			14. MOTHER'S MAIDEN NAME <u>Annice E. Nash</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>170-12-3237</u>		17. INFORMANT <u>Raymond W. Knott - Son-in-law</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cadise Disease</u> 4344 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>E. Linhardt</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>9-5-66</u>			
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		22. DATE SIGNED <u>9-15-66</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>19 Sept. 66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Blon Haven Memorial Pk. Blon Burnie H.A.C. Md.</u>	
23d. LOCATION (City or Town) (County) (State) <u>Blon Burnie H.A.C. Md.</u>		24. FUNERAL DIRECTOR <u>R. W. W. W.</u>		25a. REC'D BY REGISTRAR <u>SEP 19 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

2025

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

12212

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12207

1. PLACE OF DEATH a. COUNTY <u>A.A. CO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore -</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. - NORTH ARUNDEL - HOSP.</u>		e. STREET ADDRESS <u>1533 Tunlaw Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Bernard W. Kolodzi</u>		4. DATE OF DEATH Month <u>9</u> Day <u>25</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/12/17</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WELDER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Kolodzi</u>		14. MOTHER'S MAIDEN NAME <u>KATHERINE ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES.</u>		16. SOCIAL SECURITY NO. <u>WW 2 216-07-9752</u>	
17. INFORMANT <u>MRS. ANNA I. KLODOZI</u>		Address <u>(SAME)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Choke</u> <u>4344</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED <u>9-24-66</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9/28/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>DULANEY VALLEY CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>
24. FUNERAL DIRECTOR <u>LEONARD J. Ruck, Inc. Balto. Md. 21214</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 29 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

15801

15801

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12213
CERTIFICATE OF DEATH
12208

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>6 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel Gen. Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riviera Beach</u> d. STREET ADDRESS <u>#210 Harlem Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LILLIAN V. KREIDER</u>		4. DATE OF DEATH Month <u>SEPT</u> Day <u>11</u> Year <u>1966</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 11, 1910</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>14</u>	11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Max Votel</u>		14. MOTHER'S MAIDEN NAME <u>Freida Singer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Harry E. Kreider (Husband)</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PRIMARY BRONCHOGENIC CARCINOMA</u> 1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>1621</u> DUE TO (c) <u>1621</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CORONARY ARTERY DISEASE</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>1958</u> to <u>1966</u> , that (I) (we) last saw the deceased alive on <u>SEPT 10 1966</u> , and that death occurred at <u>2:20 P.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Arthur Lankford Jr. MD</u>		22b. DATE SIGNED <u>9-11-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>ARTHUR LANKFORD, JR., M. D.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 14, 66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Park</u>		23d. LOCATION (City, town or county) (State) <u>Howard Co. Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Judge</u>		25a. REC'D BY REGISTRAR <u>SEP 13 1966</u>	
24. ADDRESS <u>Singleton Funeral Home</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

6.25 6.25 6.25 6.25 6.25

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12214

CERTIFICATE OF DEATH

12209

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 10 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Rt-2, Box-417	
3. NAME OF DECEASED (Type or print) First Fred Middle Newton Last LONDON		4. DATE OF DEATH Month September Day 28 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 14, 1879
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret. machinist		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (County & State, or foreign country) Morral Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Lymon Landon		14. MOTHER'S MAIDEN NAME Olive Eager	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 716-12-1541	
17. INFORMANT Harry E. Landon-son same as #2 above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1992 DUE TO Leucemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinomatosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) physician attended the deceased from June 1965 , 19 Sept. 28 , 19 66 , that (I) did last saw the deceased alive on Sept. 28 , 19 66 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE T. G. Osius		22b. DATE SIGNED 9/28/66	
22c. PHYSICIAN'S NAME (Type) T. G. Osius, M.D.		22d. ADDRESS 77 Franklin St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-removal Oct. 1, 1966 West Side Cemetery	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State) Shamokin Dam Snyder Pa.
24. FUNERAL DIRECTOR Beverley E. Hopping - Hopping Funeral Home		25a. REC'D BY REGISTRAR DATE OCT 3 1966	
ADDRESS Annapolis, Md.		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Department of Health. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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* 67-21098-1, J.E. McInnis V*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12215

122111

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MD</u> b. COUNTY <u>A.A. Co.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HANOVER</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HANOVER</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>FOREST AVE.</u>				d. STREET ADDRESS <u>FOREST AVE</u>			
3. NAME OF DECEASED (Type or print) <u>MORLEY H. LEATHERWOOD</u>				4. DATE OF DEATH Month <u>9</u> Day <u>28</u> Year <u>1966</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/19/1966</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>69</u> Days <u>69</u>		IF UNDER 24 HRS. Hours <u>69</u> Min. <u>69</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>B. & D. R.A.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>JOSHUA LEATHERWOOD</u>	
14. MOTHER'S MAIDEN NAME <u>AUGUSTA HOOD</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>705072464</u>		17. INFORMANT <u>RUTH LEATHERWOOD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>1538</u> DUE TO <u>Carcinoma Colon -</u> Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO <u>Extensive metastasis to liver</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1538</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year 8 mos.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour e.m. <u>19</u> p.m.		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)		21. I certify that (I) (this hospital) attended the deceased from <u>Sept 28</u> to <u>Sept 28</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Sept 28</u> , 19 <u>66</u> , and that death occurred at <u>2:10</u> P.M. from the causes and on the date stated above.	
22a. SIGNATURE <u>Fredrick V. Butler</u>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Sept 28 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>FREDERICK V. BUTLER</u>		22d. ADDRESS <u>1014 Francis Ave Baltimore</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/1/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ZION</u>		23d. LOCATION (City; town or county) <u>HOWARD CO.</u>		(State)		24. FUNERAL DIRECTOR'S SIGNATURE <u>E.S. MacNabb</u>	
ADDRESS <u>301 FREDERICK RD</u>		25a. REC'D BY REGISTRAR <u>DATE OCT 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1153

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12216

CERTIFICATE OF DEATH

12211

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MARGARETS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARNOLD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BAY MANOR Nursing Home</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>MARIE</u> Middle <u>M.</u> Last <u>LEDERHOS</u>		4. DATE OF DEATH Month <u>9</u> Day <u>7</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-22-1878</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JACOB M. LEDERHOS</u>		14. MOTHER'S MAIDEN NAME <u>MARIA SCHELL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>OTELIA L. MILLER #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: } (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>8/26</u> , 19 <u>66</u> , to <u>9/7</u> , 19 <u>66</u> , that (I) (we) saw the deceased alive on <u>9/6</u> , 19 <u>66</u> , and that death occurred at <u>6 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Richard I. Hochman</u>		22b. DATE SIGNED <u>9/9/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard I. Hochman, M.D.</u>		22d. ADDRESS <u>59 Franklin St., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9-10-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ASBURY</u>		23d. LOCATION (City or Town) (County) (State) <u>ARNOLD A.A. MD.</u>	
24. FUNERAL DIRECTOR <u>John M. Lytle & Sons Annapolis, Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 13 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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A.A. Co.

MD
Annotd

Bay Manor Nursing Home

Marie

M. Lederhos

10-22-1878 87

Housewife

German

Marie Schell

Otelia L. Miller #2

Jacob M. Lederhos

— 04

Annotd A.A. MD

Agency

9-10-10

Let M. of London University, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 13, 14 Film G381 9/26/66 mh

CERTIFICATE OF DEATH

12217

12212

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 13 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Avalon Shores	
3. NAME OF DECEASED (Type or print) First Middle Last Eugene LEE		4. DATE OF DEATH Month Day Year September 12 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1904
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 12 19 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Shadyside Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Elizabeth Lee	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 216185880	
17. INFORMANT Gladys Lee, Shadyside Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 732X (b) Waldenstroem's macroglobulinemia DUE TO (c) 4 years		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Anemia		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (do not) attended the deceased from Sept. 2, 1966 , to Sept. 12, 1966 , that (I) (do not) last saw the deceased alive on Sept. 12, 1966 , and that death occurred at 5:15 AM , from causes and on the date stated above.			
22a. SIGNATURE Charles W. Kinzer		22b. DATE SIGNED Sept. 12, 1966	
22c. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M.D.		22d. ADDRESS South RivMedCent., Edgewater, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-14-66	23c. NAME OF CEMETERY OR CREMATORY Woodfield	23d. LOCATION (City or Town) (County) (State) Galesville AA Md.
24. FUNERAL DIRECTOR Bernard Hardisty		25a. REC'D BY REGISTRAR DATE SEP 20 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

12218

CERTIFICATE OF DEATH

12218

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 9 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Edgewater		d. STREET ADDRESS Rt-2, Box-85	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edith Middle I. Last LEITCH		4. DATE OF DEATH Month September Day 21 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 4, 1898
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) HOME		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (County & State, or foreign country) EDGEWATER, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Lloyd W. Kirby		14. MOTHER'S MAIDEN NAME SARAH LEE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT PRESTON D. LEITCH #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 CORONARY THROMBOSIS DUE TO (b) HYPERTENSIVE CARDIO-VASCULAR DIS DUE TO (c) 15 YEARS		INTERVAL BETWEEN ONSET AND DEATH 30 MINUTES	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DIABETES MELLITUS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the board) attended the deceased from April 19 57 , to Sept. 21, 19 66 that (I) (we) last saw the deceased alive on Sept. 21, 19 66 , and that death occurred at 9:50 AM from causes on and on the date stated above.			
22a. SIGNATURE Edward S. Beck		22b. DATE SIGNED 9-21-66	
22c. PHYSICIAN'S NAME (Type) Edward S. Beck, M.D.		22d. ADDRESS 73 Franklin St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9-23-66	
23c. NAME OF CEMETERY OR CREMATORY HILLCREST		23d. LOCATION (City or town) (County) (State) ANNAPODIS MD.	
24. FUNERAL DIRECTOR John M. Long & Sons Annapolis, Md.		25a. REC'D BY REGISTRAR SEP 22 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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Home Address

Home Address

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Home
 Floyd W. Kirby
 Housewife Exempter, Md. A.S.
 JARAH YEE
 Preston D. Leitch #2

Home Address

Home Address

Home Address

Home Address

Home Address

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12219

12214

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. LENGTH OF STAY IN lb D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) A. A. GEN. HOSPT. D.O.A.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN P. LEUNES		4. DATE OF DEATH SEPT 25 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 23 1894
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. RESTAURATEUR		10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT	
11. BIRTHPLACE (State or foreign country) ARNA GREECE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PETER LEUNES		14. MOTHER'S MAIDEN NAME FRANCES KARAMBELAS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 216-32-7401	
17. INFORMANT FRANCIS J. LEUNES W. LAKE DR. ANNAP. MD.		Address BAY RIDGE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Anoxia 4344 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E. Linhardt EXAMINER'S NAME (Type)		22. DATE SIGNED 9/25/66	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEPT 27, 1966	
23c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEM.		23d. LOCATION (City, town or county) (State) ANNAPOLIS MARYLAND	
24. FUNERAL DIRECTOR JOHN M. TAYLOR'S SONS ANNAPOLIS MD.		25a. REC'D BY REGISTRAR SEP 28 1966	
ADDRESS ANNAPOLIS MD.		25b. REGISTRAR'S SIGNATURE John M. Taylor	

John M Taylor - 2nd Avenue MD

Buena set 27th St Mary's Cem

Baltimore Maryland

E. Linbeck

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Arthur Jones

216-22-7401 Francis J Leary with Dr. James MD

Francis Karambelas

PETER LEARY

RET RESTAURANT ARNA GREECE USA

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12220

CERTIFICATE OF DEATH

12215

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 12-1		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 2 Washington Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Naomi		First Mae		Middle LOWMAN		Last LOWMAN		4. DATE OF DEATH Month September	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 31, 1914		9. AGE (In years last birthday) 51 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME GEORGE GARDNER				14. MOTHER'S MAIDEN NAME UNK					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. —		17. INFORMANT KENNETH F. LOWMAN #2		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 490X (c) Unknown								INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Sept. 9, 1966 , to Sept. 10, 1966 that (I) (we) saw the deceased alive on Sept. 10, 1966 , and that death occurred at 2:45 A.M. , from causes and on the date stated above.									
22a. SIGNATURE Richard I. Hochman		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/12/66			
22c. PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D.		22d. ADDRESS 59 Franklin Street, Annapolis, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9-13-1966		23c. NAME OF CEMETERY OR CREMATORY MAYO MEMORIAL CEM		23d. LOCATION (City or Town) (County) (State) MAYO A.A.C. MD.			
24. FUNERAL DIRECTOR JOHN M. TAYLOR-SONS		ADDRESS ANNAPOLIS MD		25a. REC'D BY REGISTRAR SEP 13 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12220

12220

STATE OF TEXAS

George Garrock
Home
Mrs. W. F. Garrock
No. 2
Kenneth F. Garrock

Barbar 9-12-1944 Memo Memorandum Mayo
John M. Tarrington's Annotated Memo

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
12221						CERTIFICATE OF DEATH			12216		
1. PLACE OF DEATH a. COUNTY <u>A. Arundel</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. Arundel</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN 1b <u> </u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena. (Solley Rd)</u> 12-1					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>						d. STREET ADDRESS Edmond Road, Pasadena <u>RT # 9 Box 180-A</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>OTTO</u> First <u>FRANCIS</u> Middle <u>LUEDTKE</u> Last						4. DATE OF DEATH Month <u>Sept.</u> Day <u>29</u> Year <u>1966</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>5/3/1914</u>		9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Punch Press Operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Natl. Plastic Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>		
13. FATHER'S NAME <u>Otto Luedtke</u>						14. MOTHER'S MAIDEN NAME <u>(Unknown)</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No.</u> <u>None</u>				16. SOCIAL SECURITY NO. <u>219-05-9544</u>		17. INFORMANT <u>Wife</u> <u>MRS. HILDA LUEDTKE</u> Address <u>St. 9 Box 180-A Pasadena Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SHOCK</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Acute myocardial infarction</u> (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (o)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>9/28/</u> , 19 <u>66</u> , to <u>9/29/</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9/29/</u> , 19 <u>66</u> , and that death occurred at <u>12:00 PM</u> , from causes <u> </u> and on the date stated above.											
22a. SIGNATURE <u>Edmond I. Moushabeck</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>EDMOND I. MOUSHABEK</u>						22d. ADDRESS <u>510 HARLEY STATION ROAD GLEN BURNIE, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>OCT. 3, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie, Md</u>					
24. FUNERAL DIRECTOR <u>Richard V. Singleton</u>						ADDRESS <u>Glen Burnie</u>		25a. REC'D BY REGISTRAR <u>OCT 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

Abstract

1550

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12222						12217					
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> c. LENGTH OF STAY IN 1b <u>00</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <th colspan="6">2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> d. STREET ADDRESS <u>34262</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></th>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> d. STREET ADDRESS <u>34262</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Rachel</u> First <u>Mackall</u> Middle <u>Mackall</u> Last				4. DATE OF DEATH <u>September 30</u> Month <u>19 66</u> Day <u>19 66</u> Year							
5. SEX <u>F.</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/10/1890</u>		9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Watts</u>						14. MOTHER'S MAIDEN NAME <u>Elizabeth Watts</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <u>Alene Little Rt. 5 Bldg 73 Anna, Md.</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>myocardial infarction</u> DUE TO (c) <u>arteriosclerotic cardiovascular disease</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 9</u> , 19 <u>66</u> , to <u>Sept. 30</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Aug. 9</u> , 19 <u>66</u> , and that death occurred at <u>3:40 PM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Ray M. Smith</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/30/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Ray M. Smith, M. D.</u>						22d. ADDRESS <u>Hahn Professional Bldg., Severna Pk., Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>10-4-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Tyrone Neck</u>		23d. LOCATION (City, town or county) (State) <u>Severna Park, Md.</u>					
24. FUNERAL DIRECTOR <u>William Reese Jr. Curran, Md.</u>				ADDRESS		25a. REC'D BY REGISTRAR <u>DET 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12223

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12218

1. PLACE OF DEATH a. COUNTY A. HCO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY Harris	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLAN BURNIE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A - NORTH ARUNDEL HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Leonard Middle G. Last MARION		4. DATE OF DEATH Month 9 Day 21 Year 1966	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/25/15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction Ohio	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Alex Marion		14. MOTHER'S MAIDEN NAME Violet Rowe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 278-05-1836	
17. INFORMANT Mrs. Lillian Marion-Rt. 4, Box 432, Pasadena, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DeShule needles (c) DeShule needles		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E. L. Shardt		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) E. L. Shardt		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) 9.21.66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-24-1966	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR George J. Gonce - 4001 Ritchie Hwy., Baltimore		25a. REC'D BY REGISTRAR SEP 26 1966	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12224					12219						
1. PLACE OF DEATH a. COUNTY Anne Arundel,					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY 3703 N. 14th St., Arlington, Va.						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville, Md.					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington, Virginia						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Knollwood Manor Nursing Home					d. STREET ADDRESS Millersville, Md.						
3. NAME OF DECEASED (Type or print) First Mary Middle Ellen Last Martin					4. DATE OF DEATH Month Sept. Day 24 Year 19 66						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/15/81		9. AGE (in years last birthday) 85 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 1 Days 9 Hours 9 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Monaca, Pa.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Gruver					14. MOTHER'S MAIDEN NAME Martha Carr						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown					16. SOCIAL SECURITY NO.						
17. INFORMANT Mrs. Getz					Address 2450 South 5th St Steelton, Pa.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral artery thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) —										INTERVAL BETWEEN ONSET AND DEATH 1 Hour many years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Previous cerebral thrombosis, pneumonia, hypertension, heart failure										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 30 August 1966 , to 24 Sep , 19 66 , that (I) (we) last saw the deceased alive on 18 Sep 19 66 , and that death occurred at M , from the causes and on the date stated above.											
22a. SIGNATURE Charles W. Kinzer					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 27 Sep 66				
22c. PHYSICIAN'S NAME (Type) Charles W. Kinzer, M. D.					22d. ADDRESS South River Medical Bldg, Edgewater, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 9-29-66		23c. NAME OF CEMETERY OR CREMATORY Spring Hill		23d. LOCATION (City, town or county) (State) Shippensburg, Pa.					
24. FUNERAL DIRECTOR Arnold M. Zimmerman					ADDRESS Shippensburg, Pa.		25a. REC'D BY REGISTRAR SEP 30 1966				
							25b. REGISTRAR'S SIGNATURE Charles Judge				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12220

1. PLACE OF DEATH a. COUNTY <u>A-A-Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A-A-Co.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Old County Road</u>		d. STREET ADDRESS <u>Old County Rd</u>	
3. NAME OF DECEASED (Type or print) <u>J. LORETTO MCGEADY</u>		4. DATE OF DEATH <u>9-9-1966</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 21 1892</u>
9. AGE (in years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRINCIPAL</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>ELEM. School</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Allegheny Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John McGEADY</u>		14. MOTHER'S MAIDEN NAME <u>Julia CAVANAUGH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>EAMONN McGEADY</u>		Address <u>1435 Whiteford Rd. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>4201</u> DUE TO (b) <u>Hypertensive Cardiovascular disease</u> Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug.</u> , 1958, to <u>Sept.</u> , 1966, that (I) (we) last saw the deceased alive on <u>Sept. 9</u> , 1966, and that death occurred at <u>3A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Francis I. Codd</u>		22b. DATE SIGNED <u>Sept 11, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Francis I. Codd M.D.</u>		22d. ADDRESS <u>Severna Park, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-17-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MEADOWRIDGE</u>		23d. LOCATION (City, town or county) (State) <u>DORSEY Md</u>	
24. FUNERAL DIRECTOR <u>Robert S. Barranco</u>		25a. REC'D BY REGISTRAR <u>SEP 13 1966</u>	
ADDRESS <u>Severna Park</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1888

1888

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12226

12221

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 4 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. STREET ADDRESS 100 Old Annapolis Blvd.	
3. NAME OF DECEASED (Type or print) First Middle Last Grover Cleveland MORGAN		4. DATE OF DEATH Month Day Year September 21 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1884
9. AGE (In years lost birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY PRINTING Co	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME late Charles Morgan		14. MOTHER'S MAIDEN NAME late Mary M. Mezich	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Anna Morgan		Address Above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery DUE TO (b) Myocardial infarction DUE TO (c) Arteriosclerotic cardiovascular Disease			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the doctor) attended the deceased from 9/18 , 19 66 , to Sept. 21 , 19 66 that (I) (we) last saw the deceased alive on Sept. 21 , 19 66 , and that death occurred at 11:30 P.M. M, from causes and on the date stated above.			
22a. SIGNATURE Robert O. Biern		22b. DATE SIGNED September 22, 1966	
22c. PHYSICIAN'S NAME (Type) Robert O. Biern M. D.		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 9/24/66	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem	23d. LOCATION (City or Town) (County) (State) Glen Burnie Md
24. FUNERAL DIRECTOR Robert S. Barranco, Severna Park, Md.		25a. REC'D BY REGISTRAR SEP 26 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1222

2352

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #0387 10/1/66

12227

CERTIFICATE OF DEATH

12222

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN lb 7 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 428 Castle Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) #33177 William J. Myers		4. DATE OF DEATH Month 9 Day 8 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/16/1903 9. AGE (In years last birthday) 53 63 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sea Merchant		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (County & State, or foreign country) Maryland
13. FATHER'S NAME William Myers		14. MOTHER'S MAIDEN NAME Harriet	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. 215-03-6095	17. INFORMANT Hospital Records Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Arteriosclerotic Heart Disease DUE TO (c) Inanition, Chronic Alcoholism			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Brain Syndrome			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year How am p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 888	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/1/ , 19 66 , to 9/8 , 19 66 , that (I) (we) last saw the deceased alive on 9/8/ , 19 66 , and that death occurred at 2:15 M., from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 9/8/66	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22d. ADDRESS Crownsville, Maryland	
23a. BURIAL CREMATION REMOVAL (Specify) Removal	23b. DATE THEREOF 9/14/66	23c. NAME OF CEMETERY OR CREMATORY N. of Md.	23d. LOCATION (City or Town) (County) (State) Baltimore Md.
24. FUNERAL DIRECTOR William Reese, Jr. - Crownsville, Md.		25a. REC'D BY REGISTRAR DATE SEP 19 1966	
		25b. REGISTRAR'S SIGNATURE [Signature]	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12228

CERTIFICATE OF DEATH

12223

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 30 Randall St.	
3. NAME OF DECEASED (Type or print) Harry Elmer NELSON		4. DATE OF DEATH Month September Day 12 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 7, 1912
9. AGE (In years last birthday) 54 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSURANCE	11. BIRTHPLACE (County & State, or foreign country) Annapolis, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME JOHN A. NELSON	
14. MOTHER'S MAIDEN NAME ALICE STEWART		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT JOHN A. NELSON #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO 4330 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) Richard I. Hochman attended the deceased from 10/29 , 19 65 , to Sept. 12, 1966 , that (1) last saw the deceased alive on Sept. 12, 1966 , and that death occurred at 4:15 PM , from causes and on the date stated above.			
22a. SIGNATURE Richard I. Hochman		22b. DATE SIGNED 9/14/66	
22c. PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D.		22d. ADDRESS 59 Franklin St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9-15-66	
23c. NAME OF CEMETERY OR CREMATORY CEDAR BLUFF		23d. LOCATION (City or Town) (County) (State) ANNAPODIS MD.	
24. FUNERAL DIRECTOR John M. Taylor		25a. REC'D BY REGISTRAR SEP 16 1966	
25b. REGISTRAR'S SIGNATURE John M. Taylor		25c. REGISTRAR'S SIGNATURE John M. Taylor	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DEPT. OF AGRICULTURE

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Insurance
John A. Nelson
Alice Stewart
John A. Nelson #2

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 3 Film G381 10/20/66 mh

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12229

12224

1. PLACE OF DEATH o. COUNTY AA.CO MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MD b. COUNTY AA.CO				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn -			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. NORTH ARUNDEL				d. STREET ADDRESS Delmont Station		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Willard J. Odenbeck				4. DATE OF DEATH Month Sept. 2, Day 9 Year 1966				
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-9-99		
				9. AGE (In years lost birthday) yrs. 67		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Julius Odenbeck				14. MOTHER'S MAIDEN NAME Catherine Shumaker				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1923 - 1924		16. SOCIAL SECURITY NO. 215-09-0143		17. INFORMANT Mrs. Mary H. Odenbeck, same as 2				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Disease 4344 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Spencer				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) F. Linhardt				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
				Address (Street, city, town, or county) 9.2.66.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6 Sept. 66		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial		23d. LOCATION (City or Town) (County) (State) Howard Co., Md.		
24. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.				25a. RECEIVED BY REGISTRAR SEP 5 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

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FOR STATE HEALTH DEPT.

12230

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12225

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gambrills		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gambrills	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Gambrills		d. STREET ADDRESS 03-1	
3. NAME OF DECEASED (Type or print) Sarah First Oliver Middle Lost		4. DATE OF DEATH September 6 19 66 Month September Day 6 Year 19 66	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/11/1904 62
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Alex Owens		14. MOTHER'S MAIDEN NAME Carrie Owens	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Jack Byrd Address 1502-41 St. Wash DC		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stabwound of chest 982X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Unknown	
20c. TIME OF INJURY Month, Day, Year Hour Unknown a.m. Unknown p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Gambrills Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate M.D.		22. DATE SIGNED September 7, 1966	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 9-11-1966	23c. NAME OF CEMETERY OR CREMATORY Wilson Memorial	23d. LOCATION (City or town) (County) (State) Gambrills Md
24. FUNERAL DIRECTOR William Reese ADDRESS Assing. Md.		25a. REC'D BY REGISTRAR SEP 13 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and return them within 72 hours after death.

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12231

CERTIFICATE OF DEATH

12226

Item #9 Film #G381 10/6/66 pc

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel Co. MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AA Co</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pen Scenic, Md.</u>		c. LENGTH OF STAY IN 1b. <u>4-27-61 to 9-28-66</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Plaza Manor Nursing Home 425 Myrtle Ave.</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charlotte Lottie Packham</u>		First Middle Last		4. DATE OF DEATH <u>9 - 28 - 1966</u>		Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-14-1871</u>	9. AGE (In years last birthday) <u>95 1/2</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Harwood</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth ?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Feaver, Plaza Manor, Inc.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Status Epilepticus</u> 4221 } DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Cardio Vascular Disease</u> (b) <u>Smoking</u> (c) <u>Smoking</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>Several hours</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-27</u> , 19 <u>61</u> to <u>9-28</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>9-28</u> , 19 <u>66</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard H. Hunt</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <u>9/28/66</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Richard H. Hunt</u>				22d. ADDRESS <u>100 Cherry Lane Glen Burnie, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-1-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. AUBURN</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u>				ADDRESS <u>802 Madison Ave.</u>		25a. REC'D BY REGISTRAR <u>SEP 30 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

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Chapman

VR A15ME (5)
6M 1/66

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UNITED STATES DEPARTMENT OF AGRICULTURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12233					12228						
1. PLACE OF DEATH a. COUNTY AA					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY AA						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 5307 Fernpark Ave - Baltimore						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) North Arundel Hospital					d. STREET ADDRESS 5307 Fernpark Ave Howard Park Baltimore						
3. NAME OF DECEASED (Type or print)			First JOSEPHINE		Middle		Last POOLE		4. DATE OF DEATH Month 9 Day 2 Year 1966		
5. SEX F		6. COLOR OR RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/29/01		9. AGE (In years last birthday) 65 yrs.		6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cook				10b. KIND OF BUSINESS OR INDUSTRY Retail		11. BIRTHPLACE (County & State, or foreign country) N. Carolina				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. 10		17. INFORMANT James Little			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 8/29/66 to 9/2, 1966, that (I) (we) last saw the deceased alive on 9/1/66, and that death occurred at 3A M, from the causes and on the date stated above.											
22a. SIGNATURE J. B. Ramirez				M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 9/2/66			
22c. PHYSICIAN'S NAME (Type) J. B. RAMIREZ MD.				22d. ADDRESS 3927 ANNAPOLIS RD Baltimore 27 1672 NORTHBOURNE RD Baltimore 12							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 9-6-66		23c. NAME OF CEMETERY OR CREMATORY Arbutus Cem			23d. LOCATION (City, town or county) (State) Arbutus, Md			
24. FUNERAL DIRECTOR Chas O. Wilson 1600 Brompton Ave.				ADDRESS		25a. REC'D BY REGISTRAR SEP 7 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

15551

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12234 CERTIFICATE OF DEATH 12229

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN b. <u>12</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>A. U. General Hosp. R.T.D. 2 Bldg 296A</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>W.A.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>R.T.D. 2 Bldg 296A</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Louis Porter</u> First Middle Last 4. DATE OF DEATH <u>9 26 1966</u> Month Day Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>Col.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>10/15/96</u> 9. AGE (In years last birthday) <u>69</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Horace Porter</u> 14. MOTHER'S MAIDEN NAME <u>Zatie Thomas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>W.W.I</u> 16. SOCIAL SECURITY NO. <u>26-05-5060</u> 17. INFORMANT <u>Edna Porter - R.T.D. 2 Bldg 296A Annapolis</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>auto exhaust arrest</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertensive stroke, vascular disease</u> DUE TO (c) <u>myocardial infarction</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>9 20 66</u> 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u> 20f. (City or town) (County) (State) <u>Annapolis W.A. Md.</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>9-24-66</u> to <u>9-26-66</u> , that (I) (we) last saw the deceased alive on <u>9-24-66</u> , and that death occurred on <u>9-26-66</u> , from the causes and on the date stated above.		22a. SIGNATURE <u>A. T. Allen</u> M.D. 22b. DATE SIGNED <u>9-26-66</u> 22c. PHYSICIAN'S NAME (Type) <u>A. T. Allen</u> 22d. ADDRESS <u>612 G Street NW</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>9/29/66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Broad Peak</u> 23d. LOCATION (City, town or county) (State) <u>St. Margaret, Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, II - Annapolis, Md.</u> ADDRESS <u>St. Margaret, Md.</u> 25a. REC'D BY REGISTRAR <u>SEP 27 1966</u> 25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>	

1888

CERTIFICATE OF DEATH

1888

State of New York
County of New York

City of New York

Ward of New York

Block of New York

Lot of New York

House of New York

Street of New York

City of New York

County of New York

State of New York

Year of New York

Month of New York

Attest: _____

CERTIFICATE OF DEATH

12235

12230

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Bowie</u>		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> 30-4
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>		d. STREET ADDRESS <u>1672 Northbourne RD</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Jorge</u> Middle <u>Hermenegildo</u> Last <u>Ramirez</u>		4. DATE OF DEATH Month <u>SEPT</u> Day <u>4</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-13-03</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Meats</u>	11. BIRTHPLACE (County & State, or foreign country) <u>SANTIAGO DE CUBA</u>
12. CITIZEN OF WHAT COUNTRY? <u>CUBA</u>		13. FATHER'S NAME <u>JORGE</u>	
14. MOTHER'S MAIDEN NAME <u>CARIDAD</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>J.B. RAMIREZ MD</u> Address <u>Baltimore 12 MD</u> <u>1672 Northbourne Rd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u> </u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>LYMPHOSARCOMA; Pyelonephritis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>AUG 29, 1966</u> , to <u>Sept 4, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept 4, 1966</u> , and that death occurred at <u>8:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Joseph A. Mead Jr. MD</u>		22b. DATE SIGNED <u>Sept 4, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH A. MEAD, JR., M.D.</u>		22d. ADDRESS <u>SEVERNA PARK, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-7-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>G. Howard Strong</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 5 1966</u>	
ADDRESS <u>3207 W. North Ave.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

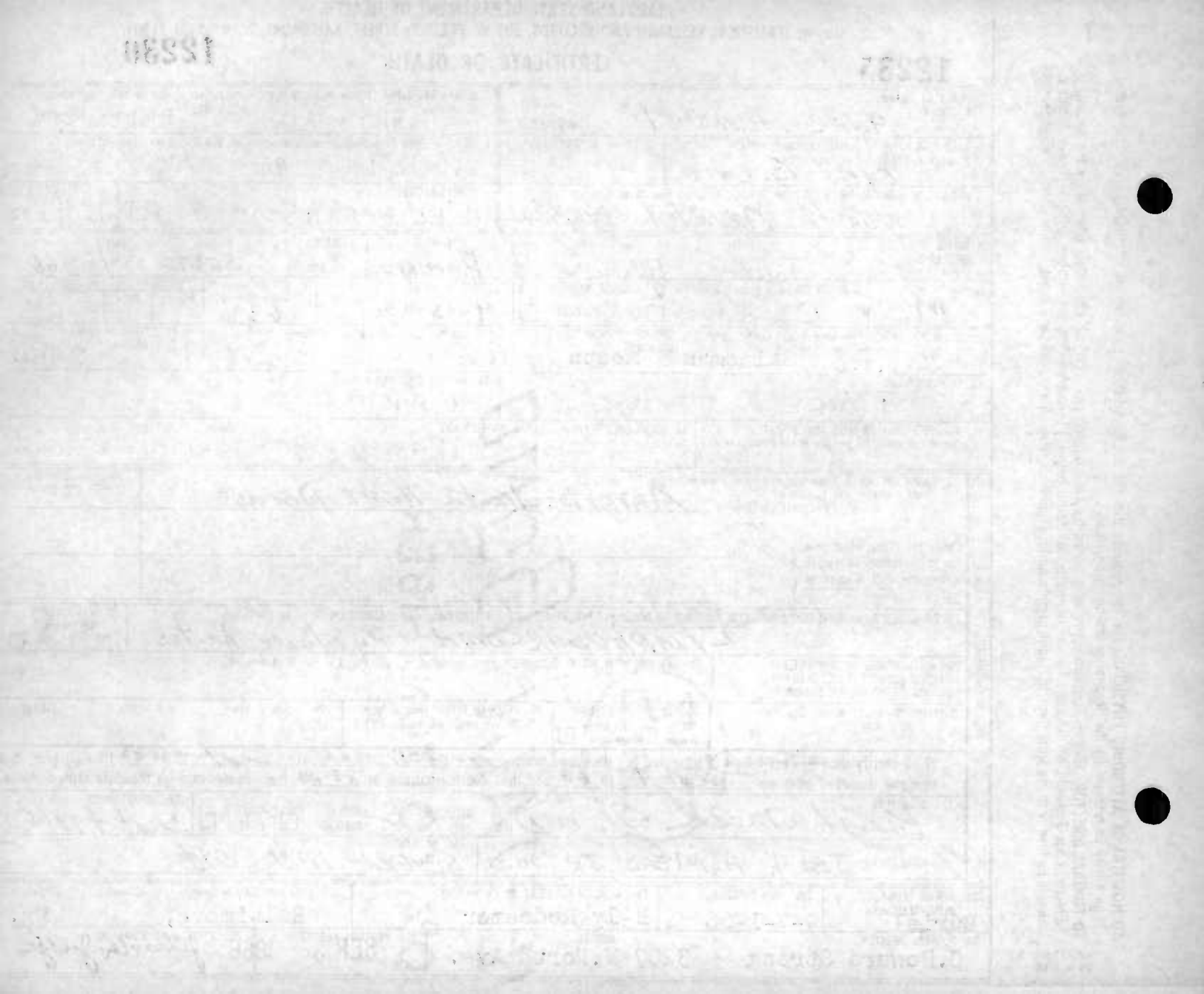
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15580

INSTITUTE OF OILS

15580



12236

CERTIFICATE OF DEATH

12231

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Churchton		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Churchton		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS Franklin Manor			
3. NAME OF DECEASED (Type or print) First Middle Last Paul Dean REMSEN				4. DATE OF DEATH Month Day Year Sept 5 19 66			
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14, 06		9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) US Gov't - Ret		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) Ind.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Melvin Remsen				14. MOTHER'S MAIDEN NAME Goodnight			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes Peacetime		16. SOCIAL SECURITY NO. 226-44-8010		17. INFORMANT Address Mrs. Juanita H Remsen - Wife			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4201 DUE TO Arteriosclerotic heart disease of coronary arteries Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Immediate years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART I(a) Diabetes mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Jan , 19 61 , to Sept 5 , 19 66 , that (I) (we) last saw the deceased alive on Aug 15 , 19 66 , and that death occurred at 5A M, from causes and on the date stated above.							
22a. SIGNATURE Willard F. Smith		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/5/66			
22c. PHYSICIAN'S NAME (Type) Willard F. Smith, M.D.		22d. ADDRESS Shady Side, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sep 8, 1966		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat Cem		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR ADDRESS J. Wm. Lee & Sons F. H. 3004th NE, Wash				25a. REC'D BY REGISTRAR DATE DC SEP 8 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reburial, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12237

CERTIFICATE OF DEATH

12232

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ferndale	
c. LENGTH OF STAY IN lb 5 days		d. STREET ADDRESS 8 Oaklayn Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) #33198 Hadley		4. DATE OF DEATH Month 9 Day 8 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/29/1905
9. AGE (In years last birthday) yrs. 60		10. IF UNDER 1 YEAR Months 0 Days 0 IF UNDER 24 HRS. Hours 0 Min. 0	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nathaniel Rose		14. MOTHER'S MAIDEN NAME Margaret	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unk.		16. SOCIAL SECURITY NO. 228-01-5887	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Arteriosclerosis DUE TO (c) Hypertensive Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardio Vascular Disease, Uremia, Chronic Brain Syndrome			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o.m. ----- p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/3/ , 19 66 , to 9/8/ , 19 66 , that (I) (we) last saw the deceased alive on 9/8/ , 19 66 , and that death occurred at 4:15M , from causes and on the date stated above.			
22a. SIGNATURE L. Benedict, M.D.		22b. DATE SIGNED 9/8/66	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEPT. 10, 66	
23c. NAME OF CEMETERY OR CREMATORY LAKEVIEW MEM'L PARK		23d. LOCATION (City or Town) (County) (State) BALTIMORE CO. MD.	
24. FUNERAL DIRECTOR R.V. SINGLETON		25a. REC'D BY REGISTRAR SEP 13 1966	
25b. REGISTRAR'S SIGNATURE GLEN BURNIE, MD.		25c. REGISTRAR'S SIGNATURE Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12338

DEPARTMENT OF HEALTH

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John Jones

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John Jones

12238

CERTIFICATE OF DEATH

12238

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton		c. LENGTH OF STAY IN lb 43 Yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Old Telegraph Road		d. STREET ADDRESS Old Telegraph Rd. (Rt. #1)	
3. NAME OF DECEASED (Type or print) WILLIAM T. C. ROSE		4. DATE OF DEATH Month September Day 27 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1882
9. AGE (In years last birthday) yrs. 84		10. IF UNDER 27, IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman (Ret.)		10b. KIND OF BUSINESS OR INDUSTRY Balto. Fire Dept.	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Christopher Rose		14. MOTHER'S MAIDEN NAME Annie Thomas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-22-2213	
17. INFORMANT Mr. J. Edward Rose (Son)		Address Old Telegraph Rd. Rt. 1 Box 303	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Central Infarct 4221 DUE TO Chronic Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Cardiovas. Disease DUE TO (b) Cardiovas. Disease DUE TO (c) Cardiovas. Disease		INTERVAL BETWEEN ONSET AND DEATH 5 years 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 15/66 to Sept 25, 1966 , that (I) (we) last saw the deceased alive on Sept 26-1966 and that death occurred 2 A.M. from causes and on the date stated above.			
22a. SIGNATURE Joseph M. [Signature]		22b. DATE SIGNED 9/27-66	
22c. PHYSICIAN'S NAME (Type) JOSEPH M. [Signature] M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS ODENTON, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 30/66	
23c. NAME OF CEMETERY OR CREMATORY Nichols Bethel Cemetery		23d. LOCATION (City or Town) (County) (State) Odenton, Maryland	
24. FUNERAL DIRECTOR Richard V. Singleton		25a. REC'D BY REGISTRAR Glen Burnie, Md.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE SEP 29 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

RESSE

2052

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Patuxent Mobile Estates	
3. NAME OF DECEASED (Type or print) First Ray Middle G. Last RUPP		4. DATE OF DEATH Month September Day 16 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 6, 1880
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 16 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY MATCH INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME FREDERICK RUPP		14. MOTHER'S MAIDEN NAME NETIE PATTINGALE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 276-16-3675	
17. INFORMANT LOUIS R. RUPP		Address 705 PLUMB ST. VIENNA VA.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Colon DUE TO 1538 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 9/13 , 19 66 , to Sept. 16 , 19 66 , that (I) (we) saw the deceased alive on Sept. 16 , 19 66 , and that death occurred at 7:50 AM , from causes and on the date stated above.			
22a. SIGNATURE Richard I. Hochman, M.D.		22b. DATE SIGNED 9/16/66	
22c. PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D.		22d. ADDRESS 59 Franklin St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 18 SEPT. 1966	
23c. NAME OF CEMETERY OR CREMATORY COLUMBIA GARDENS		23d. LOCATION (City or Town) (County) (State) ARLINGTON VA	
24. FUNERAL DIRECTOR RINALDI FUNERAL HOME, INC. 7400 GEORGE A AVE., N. W.		25a. REC'D BY REGISTRAR SEP 19 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

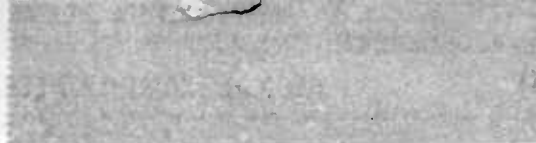
12240

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12235

1. PLACE OF DEATH a. COUNTY <u>H. H. CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <u>MD.</u> c. COUNTY <u>Telbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Livingston</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Trappe - Telbot. Co.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. - Anne Arundel Gen.</u>		d. STREET ADDRESS <u>Box 181 A Rt 50</u>	
3. NAME OF DECEASED (Type or print) First <u>Leland</u> Middle <u>L</u> Last <u>SANN JR.</u>		4. DATE OF DEATH Month <u>9</u> Day <u>20</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-31-47</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHAUFFEUR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LAUNDRY</u>	9. AGE (in years last birthday) yrs. <u>19</u>
13. FATHER'S NAME <u>LELAND L. SANN, SR.</u>		14. MOTHER'S MAIDEN NAME <u>LILLIAN OSTRANDER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-44-3729</u>	
17. INFORMANT <u>Bonnie SANN - ABOVE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun shot wound skull</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Gun shot wound - accidentally discharged.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>9/20</u> 19 <u>66</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Trappe MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. L. Hancock</u>		22. DATE SIGNED <u>9-20-66</u>	
EXAMINER'S NAME (Type) <u>E. L. Hancock</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/24/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>	23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie A.A. Md</u>
24. FUNERAL DIRECTOR <u>Robert S. Baranco</u>		25a. REC'D BY REGISTRAR <u>SEP 26 1966</u>	
ADDRESS <u>Severna Park, Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12241
CERTIFICATE OF DEATH
13636

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ft Geo G. Meade c. LENGTH OF STAY IN 1b Civ Emerg d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) KIMBROUGH ARMY HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) JESSUP d. STREET ADDRESS ROUTE #2, BOX 2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle FREDERICK Last SCHMELTZ		4. DATE OF DEATH Month SEPTEMBER Day 30 Year 19 66	
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 JUL 1889
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY B&O Railroad	11. BIRTHPLACE (County & State, or foreign country) Howard County, Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Henry Schmeltz	
14. MOTHER'S MAIDEN NAME Elizabeth unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 218-128-062		17. INFORMANT Address Mrs. Iva Lee Schmeltz, Jessup, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probably, acute myocardial infraction DUE TO (b) Chronic Obstructive Emphysema DUE TO (c) 5271 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 15 Min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I am a physician and attended the deceased from 30 Sept 19 66 , and that death occurred at 2:05 M , from the causes and on the date stated above.	
22a. SIGNATURE Robert F. Cullen Jr.		22b. DATE SIGNED 30 Sept 66	
22c. PHYSICIAN'S NAME (Type) ROBERT F. CULLEN, JR. CPT, MC		22d. ADDRESS KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 10-4-66	
23c. NAME OF CEMETERY OR CREMATORY St Johns Lutheran		23d. LOCATION (City, town or county) (State) Phleppan Corner Md	
24. FUNERAL DIRECTOR William J. Waldman		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE		DATE OCT 10 1966	

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VR A15 (4)
20M 1/65

12242

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12236

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY AA <div style="text-align: center;">MARYLAND</div>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY AA			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Green Burren		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Posaden		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) North Arundel Hospital				d. STREET ADDRESS Bx 164 LongPoint Posaden		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SAMUEL Middle F Last SELDNER				4. DATE OF DEATH Month 9 Day 4 Year 1966			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/12/12	
9. AGE (In years last birthday) 54 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Helper		10b. KIND OF BUSINESS OR INDUSTRY Brewery		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.	
13. FATHER'S NAME Abram Seldner				14. MOTHER'S MAIDEN NAME Edna Rose Dunn			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 217-22-0062		17. INFORMANT Mrs. Genevieve A. Kemp (Aunt) Address Same As #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis - 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis - DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension - Pneumonia -							INTERVAL BETWEEN ONSET AND DEATH 13 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/23 , 19 66 , to 9/4/66 , that (I) (we) last saw the deceased alive on 9/3/66 , 19 66 , and that death occurred at 6:30 A.M., from the causes and on the date stated above.							
22a. SIGNATURE J. B. Ramirez				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/4/66	
22c. PHYSICIAN'S NAME (Type) J. B. RAMIREZ				22d. ADDRESS 3927 ANNAPOLIS RD Baltimore 29 1672 NORTHBOURNE RD Baltimore 12			
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		23b. DATE THEREOF Sep't - 8/66		23c. NAME OF CEMETERY, OR CREMATORY Lorraine Park Mausoleum		23d. LOCATION (City, town or county) (State) Balto, Md.	
24. FUNERAL DIRECTOR A. V. Singleton				25a. REC'D BY REGISTRAR SEP 7 1966		25b. REGISTRAR'S SIGNATURE J. Charles Jones	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12243

CERTIFICATE OF DEATH

12237

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 11 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairhaven
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 02-1	
3. NAME OF DECEASED (Type or print) First Iva Middle Marie Last SHERBERT		4. DATE OF DEATH Month September Day 23 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 13, 1903
9. AGE (In years last birthday) yrs. 63		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (County & State, or foreign country) Anne Arundel Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Thomas Walton	
14. MOTHER'S MAIDEN NAME Maggie Marquess		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 216-46-8799		17. INFORMANT Walter W. Sherbert, Fair Haven, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA (2) 4222 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Myocardial DUE TO (c) 1 day + 3 day		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (we) attended the deceased from 9-12 , 19 66 , to Sept. 23 , 19 66 , that (I) (we) last saw the deceased alive on Sept. 23 , 19 66 , and that death occurred at 9:00 AM , from causes and on the date stated above.			
22a. SIGNATURE F M Shipley		22b. DATE SIGNED 9.23-66	
22c. PHYSICIAN'S NAME (Type) F M SHIPLEY		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 26, 1966	23c. NAME OF CEMETERY OR CREMATORY Friendship Chr. Cemetery	23d. LOCATION (City or Town) (County) (State) Friendship A. A. Co. Md.
24. FUNERAL DIRECTOR Hutchins Funeral Home Owings		25a. REC'D BY REGISTRAR SEP 26 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12238

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riva</u> <u>02-1</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>Sylvan Shores</u>	
3. NAME OF DECEASED (Type or print) First <u>Lisa</u> Middle <u>Marie</u> Last <u>Shields</u>		4. DATE OF DEATH Month <u>September</u> Day <u>3</u> Year <u>19 66</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 31, 1966</u>
9. AGE (In years last birthday) yrs. <u>2</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>6</u> Hours <u>55</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Anne Arundel, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Roy James Shields</u>		14. MOTHER'S MAIDEN NAME <u>Linda Anne Irby</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO (b) <u>776X</u> DUE TO (c) <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <u>Aug. 31, 1966</u> , to <u>Sept. 2, 1966</u> , that (I) (we) lost saw the deceased alive on <u>Sept. 2, 1966</u> , and that death occurred at <u>1:20 AM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>Willard F. Smith</u>		22b. DATE SIGNED <u>9/6/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Willard F. Smith MD</u>		22d. ADDRESS <u>Shady Side, Md.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9-6-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST</u>		23d. LOCATION (City or Town) (County) (State) <u>Annapolis MD.</u>	
24. FUNERAL DIRECTOR <u>John M. Lytton Sons Annapolis Md.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 8 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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CERTIFICATE OF DEATH

12245

12239

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 35 min.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. STREET ADDRESS Galesville	
3. NAME OF DECEASED (Type or print) First Middle Last Louis Luvean SIEGERT Jr.		4. DATE OF DEATH Month Day Year September 23 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 27, 1895
9. AGE (In years Last birthday) yrs. 70		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Building	
11. BIRTHPLACE (County & State, or foreign country) Galesville Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME LOUIS L. SIEGERT SR.		14. MOTHER'S MAIDEN NAME ELLA MAE Nutwell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates at service) Yes WWII		16. SOCIAL SECURITY NO. 6-11-11111	
17. INFORMANT SOPHIE SIEGERT		Address Galesville, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 6 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the physician) attended the deceased from 11-10-65 , to Sept. 23, 19 66 , that (I) (we) last saw the deceased alive on Sept. 23 19 66 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE J.M. SIPLEY		22b. DATE SIGNED 9-23-66	
22c. PHYSICIAN'S NAME (Type) J.M. SIPLEY		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-25-66	23c. NAME OF CEMETERY OR CREMATORY Galesville Mausoleum	23d. LOCATION (City or Town) (County) (State) Galesville, Md
24. FUNERAL DIRECTOR T.A. Hardesty		25. REC'D BY REGISTRAR Galesville, Md	
25a. DATE SEP 28 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Per telephone call to Crownsville Hosp.

CERTIFICATE OF DEATH

12246

12240

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 2 yrs. 6 mos.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		d. STREET ADDRESS 55 Shupe Street	
3. NAME OF DECEASED (Type or print) #26979 Thomas Simms		4. DATE OF DEATH Month 9 Day 27 Year 1966	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/22/1888
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Simms		14. MOTHER'S MAIDEN NAME Elizabeth	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Inanition DUE TO (c) Ca of the esophagus with metastasis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour 0 m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3/10/1964 , to 9/27/1966 , that (I) (we) last saw the deceased alive on 9/27/1966 , and that death occurred at 1:30 M, from causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED 9/27/66	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22d. ADDRESS Crownsville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-1-1966	23c. NAME OF CEMETERY OR CREMATORY Bonview H. C. Cemetery	23d. LOCATION (City or Town) (County) (State) Annapolis Md.
24. FUNERAL DIRECTOR William Reese, Jr. - Annapolis, Md.		25a. REC'D BY REGISTRAR DATE OCT 3 1966	
		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12241

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SEVERN		c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SEVERN		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 226 Rte 2 Queenstown Rd				d. STREET ADDRESS Box 226 Rte 2 Queenstown Rd			
3. NAME OF DECEASED (Type or print) William F. SNOWDEN				A. DATE OF DEATH Month SEPT Day 19 Year 1966			
5. SEX M	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 23-1879		9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. FARMER & CHAUFFEUR.			10b. KIND OF BUSINESS OR INDUSTRY A. A. Co. MD		12. CITIZEN OF WHAT COUNTRY? U.S.-D.		
13. FATHER'S NAME GEORGE SNOWDEN				14. MOTHER'S MAIDEN NAME MARY JANE SNOWDEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 218-12-7460A		17. INFORMANT BEATRICE MATTHEWS SEVERN MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio - Vascular Disease 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Atherosclerosis DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 6-14 mos. 4-6 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/15 19 66 to 9/19 19 66 , that (I) (we) last saw the deceased alive on 9/19 19 66 , and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE Char. L. Ball Jr				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. 9/19/66		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Linthicum Md.				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/23/66		23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM. PK		23d. LOCATION (City, town, or county) (State) ARBUTUS-BALTO MD 21227	
24. FUNERAL DIRECTOR'S SIGNATURE Marshall P. Hays 638 N Gilman St				25a. REC'D BY REGISTRAR DATE SEP 22 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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CERTIFICATE OF DEATH

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WILLIAM E. SNOWDEN

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12248

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12242

1. PLACE OF DEATH a. COUNTY <u>MADO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HAC</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>11111</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. - North Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Douglas L. Snyder</u>		4. DATE OF DEATH Month <u>9</u> Day <u>13</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 27, 1935</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>United Airlines</u>	
11. BIRTHPLACE (State or foreign country) <u>Watertown S. Dakota</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Earl Snyder</u>		14. MOTHER'S MAIDEN NAME <u>Daisey Eblen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>Korean</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Richard E. Snyder (Brother)</u>		Address <u>642 Haddon Ave Collingswood</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shut head Skull</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>976X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>11.1</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I of Part II of item 18.) <u>Self-inflicted gun shot wound</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>9:13</u> a.m. <u>9/13</u> 1966 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <u>At home</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>At home</u>		20f. (City or town) (County) (State) <u>HAC MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhorst</u>		22. OATE SIGNED <u>9/13/66</u>	
EXAMINER'S NAME (Type) <u>E. Linhorst</u>		M.O. <u>Charles Judge</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 16, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Fort Meyer, Virginia</u>	
24. FUNERAL DIRECTOR <u>Richard V. Singleton</u>		25a. REC'D BY REGISTRAR <u>SEP 15 1966</u>	
ADDRESS <u>Glen Burnie, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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CERTIFICATE OF DEATH

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12243

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 406 Ferndale Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Bertha Katherine SOUTH			4. DATE OF DEATH Month Day Year September 7 1966				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 1, 1881		9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED HOMEMAKER			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME ERNEST LETTAU				14. MOTHER'S MAIDEN NAME MARY MANGOLD			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. DORIS L. JAKUBOWSKI, 406 FERNDAL AVENUE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO (b) ASPIRATED FEEDING (SUSPECTED) DUE TO (c) EPIGLOTTAL INCOMPETENCE						INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC CHRONIC BRAIN SYNDROME						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (the hospital) attended the deceased from Sept. 7, 1966 , to Sept. 7, 1966 , that (I) (we) last saw the deceased alive on Sept. 7, 1966 , and that death occurred at M , from causes and on the date stated above.							
22a. SIGNATURE <i>Charles M. Judge</i>				22b. DATE SIGNED 7 Sep 1966			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 9-10-66	23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR HOWARD H. HUBBARD, 4107 WILKENS AVENUE 21229				25a. REC'D BY REGISTRAR SEP 13 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

12244

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Churchton		c. LENGTH OF STAY IN lb 5 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Franklin Manor		d. STREET ADDRESS Franklin Manor	
3. NAME OF DECEASED (Type or print) Robert		4. DATE OF DEATH Month Sept. Day 30 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 29, 1915
9. AGE (In years last birthday) yrs. 51		IF UNDER 1 YEAR Months 8 Days 1 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Repairman		10b. KIND OF BUSINESS OR INDUSTRY C.&P. Tel. Co.	
11. BIRTHPLACE (County & State, or foreign country) Maine		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Harold B. Stabler		14. MOTHER'S MAIDEN NAME Sarah Farquhar	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 578-07-8756	
17. INFORMANT Wife Address Same as Item 2.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) Arteriosclerotic heart disease DUE TO (c) 	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan , 19 63 , to Sept 30 , 19 66 , that (I) (we) last saw the deceased alive on Sept 30 , 19 66 , and that death occurred at 4¹⁵ A.M., from causes and on the date stated above.			
22a. SIGNATURE Willard F. Smith		22b. DATE SIGNED 9/30/66	
22c. PHYSICIAN'S NAME (Type) Willard F. Smith, MD		22d. ADDRESS Shady Side, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-2-66	23c. NAME OF CEMETERY OR CREMATORY Friends M. House Cem.	23d. LOCATION (City or Town) (County) (State) Sandy Spring, Maryland
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR DATE OCT 7 1966	
ADDRESS Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12251

12245

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Box 580A, Rt. 1	
3. NAME OF DECEASED (Type or print) First Erford Middle Clifton Last STRINGER Sr.		4. DATE OF DEATH Month September Day 24 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 6, 1887
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 02 Days 1 Hours 02 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cook -ret.		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (County & State, or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Erford Harrison Stringer		14. MOTHER'S MAIDEN NAME Ellen Clifton Harlow	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WW I		16. SOCIAL SECURITY NO. 014-16-2450	
17. INFORMANT Erford C. Stringer-son		Address same as #2 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO Coronary Artery Spasm (b) without thrombotic embolism (c) without thrombotic embolism		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-21-66 , 19 66 , to 9-24-66 , 19 66 , that (I) (we) last saw the deceased alive on 9-23-66 , 19 66 , and that death occurred of 7:15 A.M. M, from causes and on the date stated above.			
22a. SIGNATURE AMIS T. ALLEN		22b. DATE SIGNED 9-24-66	
22c. PHYSICIAN'S NAME (Type) AMIS T. ALLEN		22d. ADDRESS 62 Gethers St	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 28, 1966	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Ft. Meyer		23d. LOCATION (City or Town) (County) (State) VA.	
24. FUNERAL DIRECTOR Beverley E. Hopping		25. REC'D BY REGISTRAR Beverley E. Hopping	
25a. DATE SEP 27 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

20551

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12253

12247
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>FA.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Davidsonville</u>		c. LENGTH OF STAY IN 1b <u>02-1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>DAVIDSONVILLE ROAD</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Fannie Oregon Tucker</u>		4. DATE OF DEATH Month Day Year <u>9 18 1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-23-1883</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during mst of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>SUDLEY MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EDWIN NUTWELL</u>		14. MOTHER'S MAIDEN NAME <u>MARY JANE MINNICK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>E. MARCELEVA TUCKER #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertensive cardiovascular disease years</u> DUE TO (c) <u>arteriosclerotic cardiovascular disease years</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/18</u> , 19 <u>66</u> , to <u>9/18</u> , 19 <u>66</u> , that I last saw the deceased alive on <u>9/18/66</u> , 19 <u>66</u> , and that death occurred at <u>12 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>9/19/66</u> DATE SIGNED			
ACTUAL SIGNATURE <u>Charles H. Wirth</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Charles H. Wirth</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9-20-66</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ALL HALLOWS</u>	22d. LOCATION (City, town, or county) (State) <u>DAVIDSONVILLE MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 22 1966</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

2nd & 3rd

Mary Jane Minnick

3 MARCELENE TUCKER #2

2011/11/14 11:05-9 140387

David Brownville

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12254

12248

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shadyside	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gertrude Middle TURNER Last TURNER		4. DATE OF DEATH Month September Day 22 Year 19 66	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 10, 1904
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 1 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (Country & State, or foreign country) Mo		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Richard Scott		14. MOTHER'S MAIDEN NAME Jeannette Ballou	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Scott Turner		Address Shadyside	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardiovascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8 hours years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1961 , 19 61 , to Sept. 22, 1966 , that (I) (we) last saw the deceased alive on Sept 21 , 19 66 , and that death occurred at 12:42 A.M. M, from causes and on the date stated above.			
22a. SIGNATURE Willard Smith		22b. DATE SIGNED 9/22/66	
22c. PHYSICIAN'S NAME (Type) Willard F. Smith, MD		22d. ADDRESS Shady Side, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9.25.66	
23c. NAME OF CEMETERY OR CREMATORY St. Matthews		23d. LOCATION (City or Town) (County) (State) Shadyside Md	
24. FUNERAL DIRECTOR William Reese #		25a. REC'D BY REGISTRAR SEP 26 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12249

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AACO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.H. - Chubbucke Road.</u>		d. STREET ADDRESS <u>Avenue Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>GRACE</u> Middle <u>TURNER</u> Last <u>TURNER</u>		4. DATE OF DEATH Month <u>9</u> Day <u>8</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-15-1899</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MD</u>
13. FATHER'S NAME <u>John T. Gross</u>		14. MOTHER'S MAIDEN NAME <u>Julia A. Wike</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cordiac</u> 4344 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Beat & explosion - Back Truck.</u>	
20c. TIME OF INJURY Month, Day, Year <u>21</u> Hour a.m. <u>9/8</u> 1966 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhart</u>		22. DATE SIGNED <u>9/8/66</u>	
EXAMINER'S NAME (Type) <u>E. Linhart</u>		M.D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9.13-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>	23d. LOCATION (City or Town) (County) (State) <u>Annapolis Md</u>
24. FUNERAL DIRECTOR <u>William Reesett</u>		25. REC'D BY REGISTRAR DATE <u>SEP 13 1966</u>	
ADDRESS <u>Annapolis Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

15551

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STANDARD STANDARD



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12256						12250					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY <i>Anne Arundel County MARYLAND</i>						e. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie, Md.</i>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>					
c. LENGTH OF STAY IN IN <i>9-30-64 to NOW</i>						d. STREET ADDRESS <i>901 N. Bentall Street</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Plaza Manor Nursing Home</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last <i>Arthur Tyson</i>						Month Day Year <i>9 28 1966</i>					
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>Negro</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>3-7-1900</i>		9. AGE (In years last birthday) <i>66</i> yrs.		IF UNDER 1 YEAR Months Days <i>66</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>unknown</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>unknown</i>		11. BIRTHPLACE (County & State, or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>					
13. FATHER'S NAME <i>unknown</i>						14. MOTHER'S MAIDEN NAME <i>unknown</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>unknown unknown</i>						16. SOCIAL SECURITY NO. <i>214-54-9395</i>					
17. INFORMANT <i>Mrs. Frazier, Plaza Manor, Inc.</i>						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i>											
Conditions, if any, which gave rise to immediate cause (b) <i>CA. of prostate with metastasis</i>											
(a), stating the underlying cause last. (c) <i>unknown</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour e.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>9-30-64</i> , 19 <i>64</i> , to <i>9-28</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>9-28</i> , 19 <i>66</i> , and that death occurred at <i>2:00</i> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <i>Richard H. Hunt</i>						22b. DATE SIGNED <i>9/28/66</i>					
22c. PHYSICIAN'S NAME (Type) <i>RICHARD H. HUNT</i>						22d. ADDRESS <i>100 Clary Lane, Glen Burnie, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>10-1-66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn</i>		23d. LOCATION (City, town or county) (State) <i>Baltimore, Md.</i>					

MEDICAL CERTIFICATION

24. FUNERAL DIRECTOR'S SIGNATURE *Charles J. Law* ADDRESS *802 Madison Ave., Balto., Md.* 25a. REC'D BY REGISTRAR *SEP 30 1966* 25b. REGISTRAR'S SIGNATURE *Charles Judge*

18881

18881

Belmont, N.Y.

W. J. R. R.

18881

18881

Belmont, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12257						12251					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY			ANNE ARUNDEL			a. STATE			MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			FORT GEORGE G MEADE, MD			b. COUNTY			ANNE ARUNDEL		
c. LENGTH OF STAY IN 1b			DOA			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			FT GEO G MEADE, MD		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?		
KIMBROUGH ARMY HOSPITAL FGM						1830-B Forrest Ave Ft Geo G. Meade, Md			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED						4. DATE OF DEATH			5. IS RESIDENCE ON A FARM?		
(Type or print)			ANNA UNDERWOOD			First Middle Last			Month Day Year		
5. SEX			6. COLOR OR RACE			7. MARRIED			8. DATE OF BIRTH		
F			CAUCASIAN			<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			17 Aug 39		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			9. AGE (In years last birthday)			11. BIRTHPLACE (County & State, or foreign country)		
HOUSEWIFE			NONE			27 yrs			BUDAORS, HUNGARY		
13. FATHER'S NAME						12. CITIZEN OF WHAT COUNTRY?					
JOSEF GEISELHARDT						GERMAN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)						14. MOTHER'S MAIDEN NAME			17. INFORMANT		
NO						NONE			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						MRS. KATHRYN HELDT Box 117 Orion, Ill					
PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a)						Asphyxiation					
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.						Smoke Inhalation					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED?					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						Smoke Inhalation					
20c. TIME OF INJURY Month, Day, Year						20d. INJURY OCCURRED					
Hour a.m. 3:20 PM 1 Sept 19 66						While Not While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
HOME						FT GEO G MEADE, MD					
21. I certify that (I) the deceased died on 1 Sept 1966 at 3:20 PM, from the causes and on the date stated above.											
22a. SIGNATURE											
22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type)											
HENRY M. SNELL, CAPT, MC											
22d. ADDRESS											
KIMBROUGH ARMY HOSPITAL, FGM											
23a. BURIAL, CREMATION, REMOVAL (Specify)											
BURIAL											
23b. DATE THEREOF											
6 sept. 1966											
23c. NAME OF CEMETERY, OR CREMATORY											
SWEDONA LUTHERN CEMETERY											
23d. LOCATION (City, town or county) (State)											
ORION, Illinois											
24. FUNERAL DIRECTOR'S SIGNATURE											
Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland											
25a. REC'D BY REGISTRAR											
DATE SEP 7 1966											
25b. REGISTRAR'S SIGNATURE											
J Charles Judge											

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 5-63

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12255											
1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT GEORGE G. MEADE, MD c. LENGTH OF STAY IN b. DOA d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) KIMBROUGH ARMY HOSPITAL, FGGM						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT GEO G MEADE, MD d. STREET ADDRESS 1830-B Forrest Ave Ft Geo G. Meade, Md e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) KENNETH A. UNDERWOOD First Middle Last						4. DATE OF DEATH SEPT 1 19 66 Month Day Year					
5. SEX M		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 24 Dec 41		9. AGE (In years last birthday) 24 yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SOLDIER		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (County & State, or foreign country) Moline Rock Island, Ill		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME DECEASED						14. MOTHER'S MAIDEN NAME KATHRYN HELDE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES Mar 63-1 Sept 66						16. SOCIAL SECURITY NO. 360-36-1588		17. INFORMANT MRS KATHRYN HELDT Box 117 Orion, Ill Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation Conditions, if any, which gave rise to immediate cause (b) Smoke Inhalation (c) Smoke Inhalation PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Smoke Inhalation											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Smoke Inhalation					
20c. TIME OF INJURY Month, Day, Year 3:20 AM 1 Sept 19 66 Hour a.m.						20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME		20f. (City or town) (County) (State) FT GEO G MEADE, MD	
21. I certify that (I) the deceased was DOA was DOA 1 Sept 19 66 , that (I) was DOA 1 Sept 19 66 , and that death occurred at 3:20 AM from the causes and on the date stated above.											
22a. SIGNATURE Henry M. Snell 22c. PHYSICIAN'S NAME (Type) HENRY M SNELL, Capt, MC						22b. DATE SIGNED 1 SEPT 66		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22d. ADDRESS KIMBROUGH ARMY HOSPITAL, FGGM	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6 Sept. 1966		23c. NAME OF CEMETERY OR CREMATORY SWEDONA LUTHERN CEMETERY		23d. LOCATION (City, town or county) (State) ORION, Ill					
24. FUNERAL DIRECTOR'S SIGNATURE Harold S. Wade, 550 Wash., Blvd., Laurel, Maryland ADDRESS						25a. REC'D BY REGISTRAR SEP 7 1966 DATE		25b. REGISTRAR'S SIGNATURE Charles Judge			

15555

RECORDS OF DEATH

15555

SEP 1 1968

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
12259 Item #2c & d 21m 20350 9/19/66 12253											
1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDAW</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A. COUNTY</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> Glen Burnie 02-1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>ANNAPOLIS NURSING HOME</u>						d. STREET ADDRESS <u>7481 Furnace Br. Rd. VAN BUREN & BAY RIDGE</u>					
3. NAME OF DECEASED (Type or print) <u>MABEL</u>						4. DATE OF DEATH Month <u>9</u> Day <u>7</u> Year <u>1966</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-25-1880</u>		9. AGE (In years last birthday) <u>85</u> yrs. Months Days Hours Min.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>SAN FRANCISCO, CALIF</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SAMUEL GRUMAN</u>						14. MOTHER'S MAIDEN NAME <u>BERTHA ASAH</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>282-07-2943</u>		17. INFORMANT <u>VAN BUREN & BAY RIDGE. ANNAPOLIS NURSING HOME</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>20 YRS</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>29 JULY</u> , 19 <u>65</u> , to <u>7 SEPT</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7 SEPT</u> , 19 <u>66</u> , and that death occurred at <u>10 P</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Edward S. Beck</u>						22b. DATE SIGNED <u>9-7-66</u>					
22c. PHYSICIAN'S NAME (Type) <u>EDWARD S. BECK</u>						22d. ADDRESS <u>FRANKLIN ST ANNAPOLIS, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>				23b. DATE THEREOF <u>9-9-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		23d. LOCATION (City, town or county) (State) <u>BLADENSBURG MD.</u>			
24. FUNERAL DIRECTOR <u>John M. Taylor & Sons</u>				24b. ADDRESS <u>Annapolis, Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 13 1966</u>		25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>			

1880

1880

Amnopolis

1880 82

Home

Beethle, CH

9-7-86

Franklin St Amnopolis MD
Bladenburg MD

Edward S Beck

Cemetery 9-7-86 Ft Lincoln
Amnopolis MD

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (9)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12260

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12254

1. PLACE OF DEATH a. COUNTY <u>A. N. CO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ANCO</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rivera Beach.</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rivera Beach.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>209 Dale Road</u>				d. STREET ADDRESS <u>209 Dale Road.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>M.</u> Last <u>VAN FLEET</u>				4. DATE OF DEATH Month <u>9</u> Day <u>22</u> Year <u>1966</u>				
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-22-21</u>		
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Body</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Charles E. Van Fleet</u>				14. MOTHER'S MARDEN NAME <u>Ella Blanchard.</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>WW2</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Ann E. Van Fleet</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon Monoxide</u> <u>9718</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OF CONTRIBUTING CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Room closed - gasoline motor running & home</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>ANCO MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>E. L. [Signature]</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
				Address (Street, city, town, or county) <u> </u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried.</u>		23b. DATE THEREOF <u>9-26-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cms</u>		23d. LOCATION (City or town) (County) (State) <u>Baltimore MD.</u>		
24. FUNERAL DIRECTOR <u>McCallip. 237 Putnam av. Balt.</u>				25a. REC'D BY REGISTRAR <u>SEP 27 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

15520

15520

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

BP

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12261 CERTIFICATE OF DEATH 12255											
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Anne Arundel</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Burke - Severna Park</u>				c. LENGTH OF STAY IN 1b <u>4 years</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RT-1 - Box 408</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RT-1 - Jones - Severna Park</u>						d. STREET ADDRESS <u>Severna Park md</u>					
3. NAME OF DECEASED (Type or print) <u>Lottie White Webster</u> First Middle Last						4. DATE OF DEATH <u>9-23-66</u> Month Day Year					
5. SEX <u>F</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 25, 1880</u>		9. AGE (in years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Anne Arundel Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Arthur White</u>						14. MOTHER'S MAIDEN NAME <u>Johnson</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>025-26-7930</u>		17. INFORMANT <u>Theodore W. White</u> Address <u>RT-1 - Severna Park md</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Wound</u> 1810 DUE TO <u>Ce Bladder</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> , 19 <u>66</u> to <u>1966</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9-22-66</u> 19 <u>66</u> , and that death occurred at <u>9 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Robert R. Hahn</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D.		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>R. HAHN</u>						22d. ADDRESS <u>P.O. BOX 73 SEVERNA PARK, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9-26-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CARPENTERS HILL</u>		23d. LOCATION (City, town or county) (State) <u>Severna Park - RT-1 - AA Co md</u>					
24. FUNERAL DIRECTOR <u>C. S. Hicks, Jr</u> ADDRESS <u>ANNAPOLIS, md</u>						25a. REC'D BY REGISTRAR <u>SEP 27 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

18381

18381

20% COTTON 80% WOOL

WINDMILL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12262
13662

1. PLACE OF DEATH a. COUNTY Prince George Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md b. COUNTY Cal	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel - Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Laurel	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Brack Bridge Rd.		d. STREET ADDRESS Brack Bridge Road	
3. NAME OF DECEASED (Type or print) Agnes FRANCES whitehead		4. DATE OF DEATH September 23 1966	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15 1883
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Roberson		14. MOTHER'S MAIDEN NAME Mary Ganlin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Margaret Whitehead, Laurel Md		18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastric Hemorrhage 151X DUE TO Carcinoma Stomach Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 day 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive C - V - A - Rt. Hemiplegia			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/1 1966 to 9/22 1966 that (I) (we) last saw the deceased alive on 6/22 1966 and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE J M Warren M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) J M WARREN		22d. ADDRESS Laurel Md	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Burial 9-26 -66		23c. NAME OF CEMETERY OR CREMATORY St Mary Cem	
23d. LOCATION (City, town or county) (State) Laurel Md		24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	
25a. REC'D BY REGISTRAR DATE OCT 10 1966		25b. REGISTRAR'S SIGNATURE J Charles Judge	

10008

25

Adress furnished by returned

1 day
2 yrs

Greater Pennsylvania

Hypertension C-V-A-R-M

6/2 66
6/1 66
6/2 66

J. M. Warner

X

ALL TO BE
RETURNED TO
THE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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54

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12263

Items #2c & d Film #G381 10/6/66 pc

CERTIFICATE OF DEATH

12256

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MD. b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	
c. LENGTH OF STAY IN lb 67 Days		d. STREET ADDRESS 122 Wilson Blvd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALICE First Middle Last WIEGAND		4. DATE OF DEATH Month 9 Day 28 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 June 1885
9. AGE (In years lost birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 6 Days 18	11. IF UNDER 24 HRS. Hours 19 Min. 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Severn, AA Co., MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nathaniel Day		14. MOTHER'S MAIDEN NAME Emma Dyson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Victor A. Sulin, Severn, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive heart Disease DUE TO (c) years		INTERVAL BETWEEN ONSET AND DEATH 67 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/23 , 19 66 , to 9/28 , 19 66 that (I) (we) last saw the deceased alive on 9/23 , 19 66 , and that death occurred at 6:45 PM , from causes and on the date stated above.			
22a. SIGNATURE Ernest A. Leopold		22b. DATE SIGNED 9-28-66	
22c. PHYSICIAN'S NAME (Type) Ernest A. Leopold, M.D.		22d. ADDRESS 425 Ritchie Hwy. SE, Glen Burnie, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1 Oct. 66	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore 25, Md.
24. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.		25a. REC'D BY REGISTRAR DATE OCT 3 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

12264

CERTIFICATE OF DEATH

12257

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b Life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis, Md. 1618 Forest Drive		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mae Middle Belle Last WILLIAMS		4. DATE OF DEATH Month September Day 11 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1914
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (County & State, or foreign country) Anne Arundel, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME HENRY HENKENSEIFKEN		14. MOTHER'S MAIDEN NAME SARAH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. -	
17. INFORMANT WILLIAM J. WILLIAMS #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Metastatic Ca. DUE TO 1750 (b) Ca of the ovary bilateral DUE TO (c) lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) the hospital attended the deceased from Sept. 11 , 19 66 , to Sept. 11 , 19 66 , that (I) (we) last saw the deceased alive on Sept. 11 , 19 66 , and that death occurred at 1:40 AM M, from causes on and on the date stated above.			
22a. SIGNATURE William F. Krone		22b. DATE SIGNED 9-12-66	
22c. PHYSICIAN'S NAME (Type) William F. Krone, M.D.		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9-13-1966	
23c. NAME OF CEMETERY OR CREMATORY CEDAR BLUFF CEM.		23d. LOCATION (City or Town) (County) (State) ANNAPOLIS MD.	
24. FUNERAL DIRECTOR JOHN M. TAYLOR SONS ANNAPOLIS MD.		25a. REC'D BY REGISTRAR SEP 13 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

15551

15551

CERTIFICATE OF DEATH

John Doe

John Doe

John Doe

1918-10-10

Age

Age

General Hospital

11

11

WILLIAMS

WILLIAMS

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Home

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HENRY HENNINGSEN

HENRY HENNINGSEN

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WILLIAMS

45

Cor of the - every father

8-12-1918 Cedar Butte Co. Arkansas

WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12265

CERTIFICATE OF DEATH

12258

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>Gibson Island</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel</u>		d. STREET ADDRESS <u>Gibson Island, Md</u>	
3. NAME OF DECEASED (Type or print) First <u>OTIS</u> Middle <u>Harold</u> Last <u>WILLIAMSON</u>		4. DATE OF DEATH Month <u>9</u> Day <u>12</u> Year <u>1966</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-3-1893</u>	
9. AGE (In years lost birthday) <u>73</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Business man</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Indianapolis, Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>OTIS Elmer Williamson</u>		14. MOTHER'S MAIDEN NAME <u>Ada Cole Williamson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes World War I</u>		16. SOCIAL SECURITY NO. <u>216-28-7662</u>	
17. INFORMANT <u>Richard Williamson - Cockeysville Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) <u>Coronary Artery Disease</u> DUE TO (c) <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1947</u> , to <u>Sept. 12, 1966</u> that (I) (we) last saw the deceased alive on <u>August 27, 1966</u> , and that death occurred at <u>7:31 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Newland E. Day</u>		22b. DATE SIGNED <u>9-13-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Newland E. Day M.D.</u>		22d. ADDRESS <u>4 - E. 33rd St. - Baltimore, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 13/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Pikesville Md.</u>	
24. FUNERAL DIRECTOR <u>R. Singleton</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 15 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS <u>Singleton Funeral Home</u>	

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15524

RECEIVED IN DEATH

15524

Williamson

OTIS

9-2-1922

OTIS

OTIS

OTIS Elmer Williamson

Adm Cole Williamson

214 2122

Williamson Elmer

Adm Cole Williamson

CERTIFICATE OF DEATH

12266

12259

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>		d. STREET ADDRESS <u>Box 174 Elvaton M. Rt. 1</u>	
3. NAME OF DECEASED (Type or print) <u>JAMES</u> First <u>F</u> Middle <u>WOOD</u> Last		4. DATE OF DEATH Month <u>Sept</u> Day <u>26</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 24/1926</u>
9. AGE (In years last birthday) <u>40</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Elvaton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James H Wood</u>		14. MOTHER'S MAIDEN NAME <u>Emma A Stammer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-36-5441</u>	
17. INFORMANT <u>MRS Elsie E Wood (Wife)</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 7, 1966</u> to <u>Sept 26, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept 26, 1966</u> , and that death occurred at <u>8:00 P.</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Max C Frank MD</u>		22b. DATE SIGNED <u>9/26/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>MAX C FRANK MD</u>		22d. ADDRESS <u>42556 Ritchie Hwy Glen Burnie Md 21061</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Sept 29/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie Md</u>
24. FUNERAL DIRECTOR <u>Richard V Singleton</u>		25a. REC'D BY REGISTRAR <u>Glen Burnie, Md</u>	
25b. REGISTRAR'S SIGNATURE <u>Richard V Singleton</u>		DATE <u>SEP 28 1966</u>	

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RESEARCH OF DEATH

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For all of the information in this report, the following information is provided:
1. The name of the person who was the subject of the investigation.
2. The date of the investigation.
3. The name of the person who conducted the investigation.
4. The name of the person who was the subject of the investigation.
5. The name of the person who was the subject of the investigation.
6. The name of the person who was the subject of the investigation.
7. The name of the person who was the subject of the investigation.
8. The name of the person who was the subject of the investigation.
9. The name of the person who was the subject of the investigation.
10. The name of the person who was the subject of the investigation.